2017 First Quarter Newsletter

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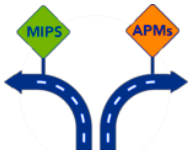
The Quick CMS Approved Way to Avoid a MACRA Penalty

Know the Consequences of Your Reporting Choices

The Medicare Access and CHIP Reauthorization Act of 2015 **(MACRA)** involves a shift to value-based payment models. The new related Quality Payment Program **(QPP)** has two tracks:



- Advanced Alternative Payment Models **(APMs)**
- Merit-based Incentive Payment System **(MIPS)**

The expectation is that most physicians will start in MIPS, which includes elements of the Physician Quality Reporting System **(PQRS)**, the Value-Based Modifier **(VM or VBM)**, and the Medicare Electronic Health Record incentive program (also called Meaningful Use).

CMS is offering a "Pick Your Pace" approach to MIPS. If MIPS is the program for you, the option you choose to follow in 2017 will determine the impact on your Medicare payments in 2019.

- **Don't participate:** If you don't submit any 2017 data, expect a negative payment adjustment.
- **Submit something/test:** This choice is your quick road to avoiding a penalty. You must submit some data, such as one quality measure, to avoid a downward payment adjustment. This option helps ensure that your system is working and that you are ready to participate at a higher level in 2018 and beyond.
- **Submit a partial year:** Submitting 90 days of 2017 data to Medicare will also keep you safe from a penalty and may even bring you a positive payment adjustment. This option means you can begin any time after Jan. 1, 2017, if you need more time to prepare.
- **Submit a full year:** Submitting a full year of QPP data is your best chance for a bonus.

Add to Your Reimbursement by Getting to Know MACRA!

The following are some resources available to aid you:

- **CMS:** From CMS's MACRA: MIPS & APMs site, you can access a QPP site. Don't miss the Education page, which includes resources like a Where to Go for Help Fact Sheet.
- **AMA:** The AMA has a MACRA site that includes an assessment tool.
- **AAPC:** AAPC offers a MACRA category in its Knowledge Center with informative articles and helpful updates.

0-Day Global Codes and Modifier 25

Codes with 0-, 10-, and 90-day global periods include reimbursement for E/M services routinely provided with the service or procedure. CMS has been seeing certain codes with 0-day global periods billed frequently (half of the time or more) with E/M codes. Because the E/M codes have modifier 25 (*Significant, separately identifiable E/M service on the same day*…) appended, they get separate reimbursement. Medicare wants to be sure those service and procedure codes often paired with an E/M are properly valued. The proposed rule listed 83 codes to check. The final rule shortens the list significantly.

Final Rule PDF → https://www.gpo.gov/fdsys/pkg/FR-2016-11-15/pdf/2016-26668.pdf
Refer to → Check out Table 8 on page 37 of the Final Rule PDF.
Extra Tip → Discussion of data collection requirements for 10-day and 90-day global periods starts on page 40 of the Final Rule PDF.

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4 Quick Facts From the 2017 MPFS Final Rule

1. The Conversion Factor Goes Up a Little

The 2017 conversion factor (click to view link) is just a bit bigger than the 2016 conversion factor:

- **2016:** 35.8043
- **2017:** 35.8887

Refer to ➔ You'll find the conversion factor listed on page 374 of the Final Rule PDF (Click to view link).

2. Non-F2F Prolonged Services

In a change from 2016, Medicare will offer separate payment for prolonged services codes (Click to view link) 99358 (*Prolonged evaluation and management service before and/or after direct patient care; first hour*) and +99359 (… *each additional 30 minutes-List separately in addition to code for prolonged service*).

Caution: Do not count time more than once. If the time is included in another Medicare Physician Fee Schedule (MPFS) service you are reporting, don't report the prolonged service codes, too.

Refer to ➔ The MPFS offers insights into proper use of these codes on page 59 of the Final Rule PDF.

3. HCPCS Is the Home of Telehealth Consult Codes

Medicare created G0508 (Click to view link)-(*Telehealth consultation, critical care, physicians typically spend 60 minutes communicating with the patient and providers via telehealth [initial]*) and G0509 (*Telehealth consultation, critical care, physicians typically spend 50 minutes communicating with the patient and providers via telehealth [subsequent]*).

The codes allow you to report telehealth services for critical care, such as in the case of stroke.

Refer to ➔ Discussion of these codes starts on page 183 of the Final Rule PDF.

4. Programs like MDPP Put Primary Care in the Limelight

The Final Rule confirms an expansion of the duration and scope of the Medicare Diabetes Prevention Program (MDPP-Click to view link). The goal of the program is to prevent type 2 diabetes in beneficiaries with pre-diabetic levels. Prevention has been seen as a way to keep patients healthier and reduce Medicare expenses.

Refer to ➔ Page 290 of the Final Rule PDF

The links below are for your reference:

➔ Final Rule PDF

➔ MPFS 2017 Final Rule

➔ Prolonged Services Codes

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Medicare HICN Format Changes

Since the start of the Medicare program, beneficiaries have used their social security number to claim benefits with a suffix that designated how they are receiving their benefits (retired, disabled, railroad worker, etc.). With enormous concern about the privacy and security of all patients around the country disclosing social security numbers to providers offices, hospitals, and other healthcare providers, CMS is changing the way that Medicare beneficiaries identify themselves starting in 2018. Like most private health insurance and Medicaid carriers, Medicare beneficiaries are going to be given a unique ID number that will not include any part of their social security number. The new format will be an alpha-numeric, eleven -digit ID as part of the Social Security Number Removal Initiative (SSNRI). The new Medicare number, formerly known as a Health Insurance Claim Number (HICN), will be replaced by the Medicare Beneficiary Identifier (MBI). Medicare beneficiaries will start receiving new cards in early 2018 with their MBI, which should be used effective April 2018. During the transition period, which will last until the end of 2019, all healthcare providers will be able to submit claims, check eligibility, and perform other routine business with either the dated Medicare HICN or the new MBI. However, providers will be strongly encouraged to update patient demographics with the new ID number. At the start of 2020, the HICN will no longer be accepted for any claim transactions. While it is more than a year away before these changes go into effect, providers are encouraged to start thinking about possible changes in workflow when it comes to registering their patients, since it will take more time to register patients, to update demographics, rework eligibility workflow, and other concerns. See the following link below for additional information and how MBIs will be created:

- *https://www.cms.gov/Medicare/SSNRI/Index.html* (General Information related to SSNRI)
- *https://www.cms.gov/Medicare/SSNRI/MBI-Format-PDF.PDF* (Fact sheet on how the MBI will be created)

2017 Coding Updates

On January 1, 2017, there will be significant changes in the CPT coding of hallux valgus corrections or bunionectomies.

28289: Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant
28291: Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; with implant
28292: Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with resection of proximal phalanx base, when performed, any method
28295: Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with proximal metatarsal osteotomy, any method
28296: Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with distal metatarsal osteotomy, any method
28297: Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with first metatarsal and medial cuneiform joint arthrodesis, any method
28298: Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with proximal phalanx osteotomy, any method
28299: Correction, hallux valgus [bunionectomy], with sesamoidectomy, when performed, with double osteotomy, any method

New ICD-10 codes:
M21.611 Bunion of *right* foot
M21.612 Bunion of *left* foot
M21.621 Bunionette of *right* foot
M21.622 Bunionette of *left* foot