2017 MEDICARE UPDATE

CHOP

June 2017

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Important to Remember

The information provided in this presentation is for informational purposes only. Information is provided for reference only and is not intended to provide reimbursement or legal advice.

Laws, regulations, and policies concerning reimbursement are complex and are updated frequently and should be verified by the user. Please consult your legal counsel or reimbursement specialist for any reimbursement or billing questions.

You are responsible for ensuring that you appropriately and correctly bill and code for any services for which you seek payment. Oplinc does not guarantee the timeliness or appropriateness of the information contained herein for your particular use.

AGENDA

- The Value Modifier (**VM**)
- The Medicare Access and CHIP Reauthorization Act (**MACRA**)
- Quality Payment Program (**QPP**)
  - The Merit-Based Incentive Program (**MIPS**)
  - Alternative Payment Models (**APM**s)
- The Medicare 2017 Final Rules
  - Medicare Physician Fee Schedule (**MPFS**)
  - Outpatient Prospective Payment System (**OPPS**)

VALUE MODIFIER

Physician Feedback

Value Modifier and the PQRS

For CY 2017 payment adjustment, physician solo practitioners and physician groups with 2+ EPs

PQRS Reporters – 3 types

1a. Group reporters – Register for GPRO Web Interface, Registry, or EHR AND meet the criteria to avoid the 2017 PQRS payment adjustment

OR

1b.Individual reporters in the group – at least 50% of EPs in the group report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment.

2. Physician Solo practitioners - Report PQRS measures as individuals AND meet the criteria to avoid the 2017 PQRS payment adjustment.

Mandatory Quality-Tiering Calculation

Groups with 2-9 EPs and solo practitioners

Upward or neutral VM adjustment based on quality-tiering (+0.0% to +2.0x of MPFS)

Groups with 10+ EPs

Upward, neutral, or downward VM adjustment based on quality-tiering (-4.0% to +4.0x of MPFS)

Non-PQRS Reporters

Do not register for GPRO Web Interface, registry, or EHR or 50% EP threshold **OR** do not avoid the 2017 PQRS payment adjustment

-2.0% (for groups with 2-9 EPs and solo practitioners)
-4.0% (for groups with 10+ EPs)
(Automatic VM downward adjustment)

Note: The VM payment adjustments are separate from the PQRS payment adjustment and payment adjustments from other Medicare sponsored programs.

2017 Value Modifier Results

	Physician Practices		Total Physicians	
	#	%	#	**%**
Due to reporting status & performance				
Downward	875	0.4%	26,973	**3.0%**
Neutral	72,475	34.7%	554,129	**62.6%**
All Upward	2,396	1.1%	12,176	**1.4%**
Additional +1.0x upward adjustment*	725	0.3%	6,639	**0.8%**
Due to non-reporting status				
Downward	133,086	63.7%	291,830	**33.0%**
All TINs subject to the Value Modifier	208,832	100.0%	885,108	**100.0%**

* Physicians receiving an additional +1.0x adjustment factor to their Medicare Physician Fee Schedule payments for treating high-complexity Medicare beneficiaries.

2015 ANNUAL QUALITY AND RESOURCE USE REPORT

AND THE 2017 VALUE-BASED PAYMENT MODIFIER

Sample Medical Practice A

LAST FOUR DIGITS OF YOUR MEDICARE-ENROLLED TAXPAYER IDENTIFICATION NUMBER (TIN): 0000

PERFORMANCE PERIOD: 01/01/2015 – 12/31/2015

ABOUT THIS REPORT FROM MEDICARE

The 2015 Annual Quality and Resource Use Report (QRUR) shows how your group or solo practice, as identified by its Medicare-enrolled Taxpayer Identification Number (TIN), performed in calendar year 2015 on the quality and cost measures used to calculate the Value-Based Payment Modifier (Value Modifier) for 2017.

In 2017, the Value Modifier will apply to all physicians in groups with two or more eligible professionals and to physicians who are solo practitioners who bill under the Medicare Physician Fee Schedule. It will not apply to eligible professionals who are not physicians.

The information contained in this report is believed to be accurate at the time of production. The information may be subject to change at the discretion of the Centers for Medicare & Medicaid Services (CMS), including, but not limited to, circumstances in which an error is discovered.

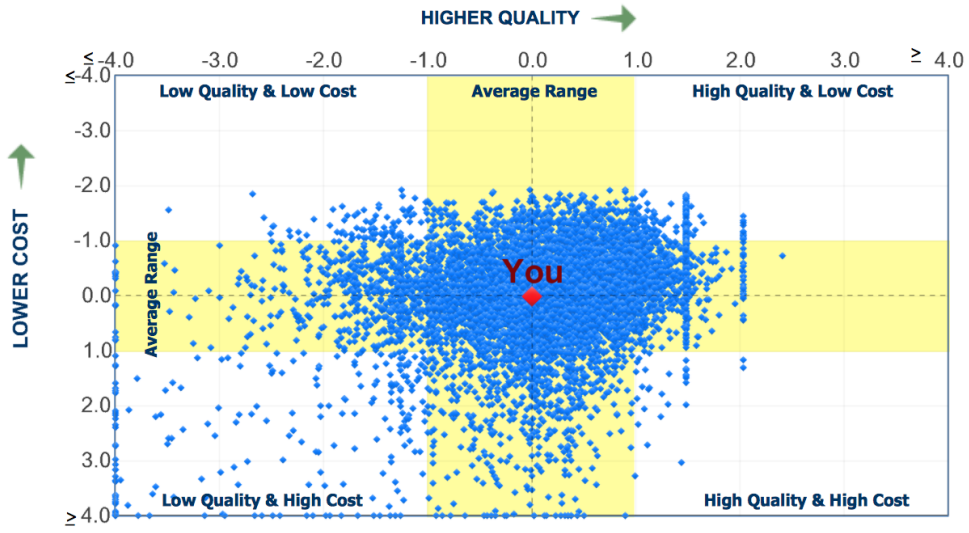
YOUR TIN'S 2017 VALUE MODIFIER

Average Quality, Average Cost = Neutral Adjustment (0.0%)

Your TIN's overall performance was determined to be average on quality measures and average on cost measures.

This means that the Value Modifier applied to payments for items and services under the Medicare Physician Fee Schedule for physicians billing under your TIN in 2017 will result in a neutral adjustment, meaning no adjustment (0.0%).

The scatter plot below shows how your TIN ("You" diamond) compares to a representative sample of other TINs on the Quality and Cost Composite scores used to calculate the 2017 Value Modifier.



Note: The scatter plot shows performance among a representative sample of all TINs with Quality and Cost Composite Scores reflecting standard deviations from the mean for each Composite Score.

2018 VM Tiering for Group Practices of 10 or More
Based on 2016 Reporting

2018 Value-Based Payment Modifier Quality Tiering (based on PY 2016)				
Cost❄ / Quality✹	Low Quality	Average Quality	High Quality	
Low Cost	+0.0%	+2.0x*	+4.0x*	
Average Cost	-2.0%	+0.0%	+2.0x*	
High Cost	-4.0%	-2.0%	+0.0%	

2018 VM Tiering for Solo Physicians and Group Practices of 2-9
Based on 2016 Reporting

2018 Value-Based Payment Modifier Quality Tiering (based on PY 2016)				
Cost❄ / Quality✹	Low Quality	Average Quality	High Quality	
Low Cost	+0.0%	+1.0x*	+2.0x*	
Average Cost	-1.0%	+0.0%	+1.0x*	
High Cost	-2.0%	-1.0%	+0.0%	

"x" refers to the upward payment adjustment factor

2018 Medicare Payment Penalties

Program	Applicable To	Adjustment Amount	Based on Calendar or Program Year (CY/PY)
PQRS	All EPs (Medicare physicians, practitioners, therapists)	-2.0% of Medicare Physician Fee Schedule (MPFS)	2016 PY
Medicare EHR Incentive Program	Medicare physicians (if not a meaningful user)	-3.0% of MPFS	2016 CY
Value Modifier	**Value Modifier** All physician and non-physician solo practitioners and physicians and non-physicians in group practices of 2 or more EPs	-2.0% for practices with 1-9 EPs -4.0% - +4.0% for groups with 10 or more EPs	2016 CY

Medicare Access and CHIP Reauthorization Act (MACRA)

- In addition to doing away with the SGR formula, MACRA further shifts Medicare payments towards value-based payments.
- MACRA mandates that the base physician payment rate will be increased annually by 0.5% from 2015 through 2019.
- From 2020 through 2025 the base physician rate will be frozen, but eligible providers will have the opportunity to receive additional payment adjustments through the new Quality Payment Program.

MACRA
QUALITY PAYMENT PROGRAM (QPP)

Providers Will Choose 1 of 2 Paths

Under the new Quality Payment Program (QPP), eligible providers will have to choose between participation in:

1. The Merit-Based Incentive Payment System (MIPS), or
2. A qualified Alternative Payment Model (APM).

Providers will be able to decide annually which program they will participate in.

Merit-Based Incentive Payment System (MIPS)

- Sunsets current Meaningful Use, Value-Based Modifier, and Physician Quality Reporting System (PQRS) penalties at the end of 2018, rolling requirements into a single program.
- Adjusts Medicare payments based on performance on a single budget-neutral payment beginning in 2019.
- Applies to physicians, nurse practitioners, clinical nurse specialists, physician assistants, and certified RN anesthetists.
- Includes improvement incentives for quality and resource use categories.

MIPS

- MIPS will measure Medicare Part B providers to develop an annual MIPS score and payment update based on 4 categories:
  1. Quality,
  2. Cost,
  3. Improvement Activities, and
  4. Advancing Care Information
- 2017 is the first performance year for MIPS and 2019 the first payment year.

Who is Included in MIPS?

- You're included in MIPS if you bill Medicare Part B more than $30,000 a year in allowable charges and provide care for more than 100 Medicare patients a year*, and are a:
  - Physician
  - Physician assistant
  - Nurse practitioner
  - Clinical nurse specialist
  - Certified registered nurse anesthetist

* On June 20, 2017 CMS published a proposed rule for 2018, the 2nd year of the QPP, that would raise the threshold for inclusion in MIPS

Who is Excluded From MIPS*

- Clinicians who are:
  - Enrolled in Medicare for the first time during the performance period (exempt until following performance year), or
  - Below the low-volume threshold – allowed charges of less than or equal to $30,000 a year or see 100 or fewer Medicare Part B patients a year, or
  - Significantly participating in Advanced APMs, receiving 25% of Medicare payments or seeing 20% of Medicare patients through an Advanced APM.

* On June 20, 2017 CMS published a proposed rule for 2018, the 2nd year of the QPP, that would raise the threshold for inclusion in MIPS

When Does the Merit-based Incentive Payment System Officially Begin?

2017
Performance Year

Performance: The first performance period opens January 1, 2017 and closes December 31, 2017. During 2017, you will record quality data and how you used technology to support your practice. If an Advanced APM fits your practice, then you can provide care during the year through that model.

March 31, 2018
Data Submission

Send in performance data: To potentially earn a positive payment adjustment under MIPS, send in data about the care you provided and how your practice used technology in 2017 to MIPS by the deadline, March 31, 2018. In order to earn the 5% incentive payment for participating in an Advanced APM, just send quality data through your Advanced APM.

Feedback

Feedback: Medicare gives you feedback about your performance after you send your data.

January 1, 2019
Payment Adjustment

Payment: You may earn a positive MIPS payment adjustment beginning January 1, 2019 if you submit 2017 data by March 31, 2018. If you participate in an Advanced APM in 2017, then you could earn 5% incentive payment in 2019.

2017 Is a Transitional Year

Three Options for MIPS Reporting in 2017

1

Full Measure Set Across All Categories

Report required MIPS measures for 90 days

or more

↓

Eligible for moderate positive payment adjustment

2

More than One Measure

Report more than one measure for 90 days or more

↓

Eligible for small positive payment adjustment

3

One Measure in Any Category

Report any measure in any category for any period of time

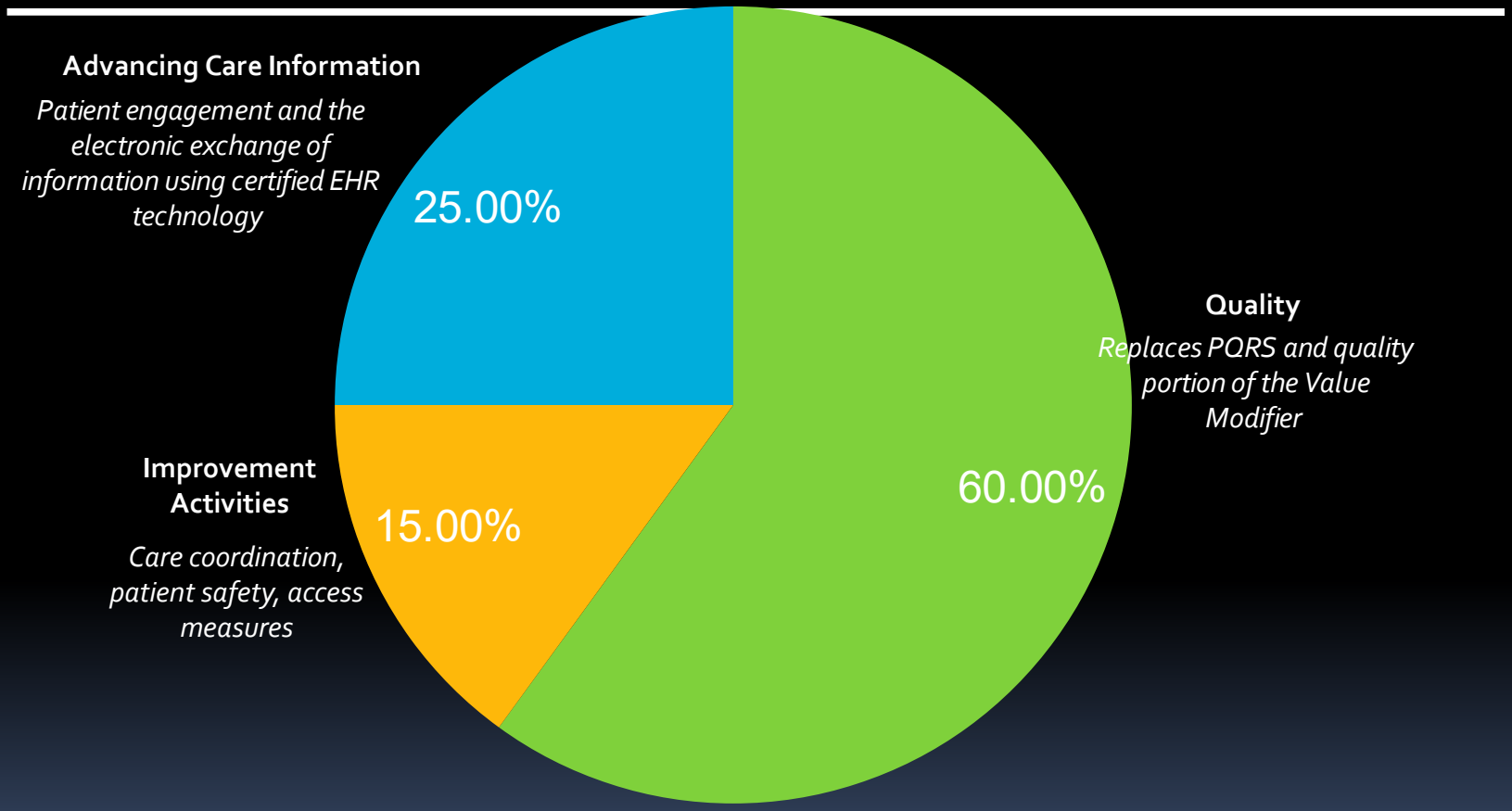
↓

Avoid penalty

In the 2017 Transition Year:

Not participating in the Quality Payment Program for the Transition Year will result in a negative 4% payment adjustment.

MIPS Performance Category Weights – Transition Year 2017



Cost measure has no reporting requirement, and will have a score of 0% score in 2017. The cost measure will have increasing value in subsequent years.

MIPS & Meaningful Use

- **If you have successfully demonstrated Medicare meaningful use in a year before 2017:**
  - Beginning with reporting periods in 2017 for the 2019 payment year, you no longer will report to the meaningful use incentive program. Instead, you'll report to MIPS and be subject to its program requirements.

- **If you are participating in the Medicare EHR Incentive Program for the first time in 2017:**
  - You must take one of the following actions by **Oct. 1, 2017,** to avoid the 2018 payment penalty:
    - Attest to the Modified Stage 2 2017 EHR Incentive Program requirements; **OR**
    - Submit a one-time hardship exception application if you are transitioning to the MIPS path of the Quality Payment Program in 2017 and plan to report on measures specified for the Advancing Care Information performance category.

www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/PaymentAdj_EPTipsheet.pdf

Alternative Payment Models (APMs)

- Alternative Payment Models (APMs) are new approaches to paying for medical care that incentivizes quality and value.
- MACRA defined APMs include:
  - CMS Innovation Center models
    - The Oncology Care Model (OCM) is a CMS Innovation Center payment and delivery model
  - Medicare Shared Savings Programs (MSSPs)
  - Demonstrations under the Health Care Quality Demonstration Program
  - Demonstrations required by federal law.

https://innovation.cms.gov

www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/APMs-in-The-Quality-Payment-Program-for-Shared-Savings-Program-SSP-webinar-slides.pdf

Only Advanced APMs Will Exclude you From MIPS

Advanced APMs in 2017

- Comprehensive ESRD Care Model (Two-Sided Risk Arrangements)
- Comprehensive Primary Care Plus (CPC+)
- Medicare Shared Savings Program/Tracks 2 and 3
- Next Generation ACO model
- Oncology Care Model (OCM) (Two-Sided Risk Arrangement)
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)

Advanced APMs must:

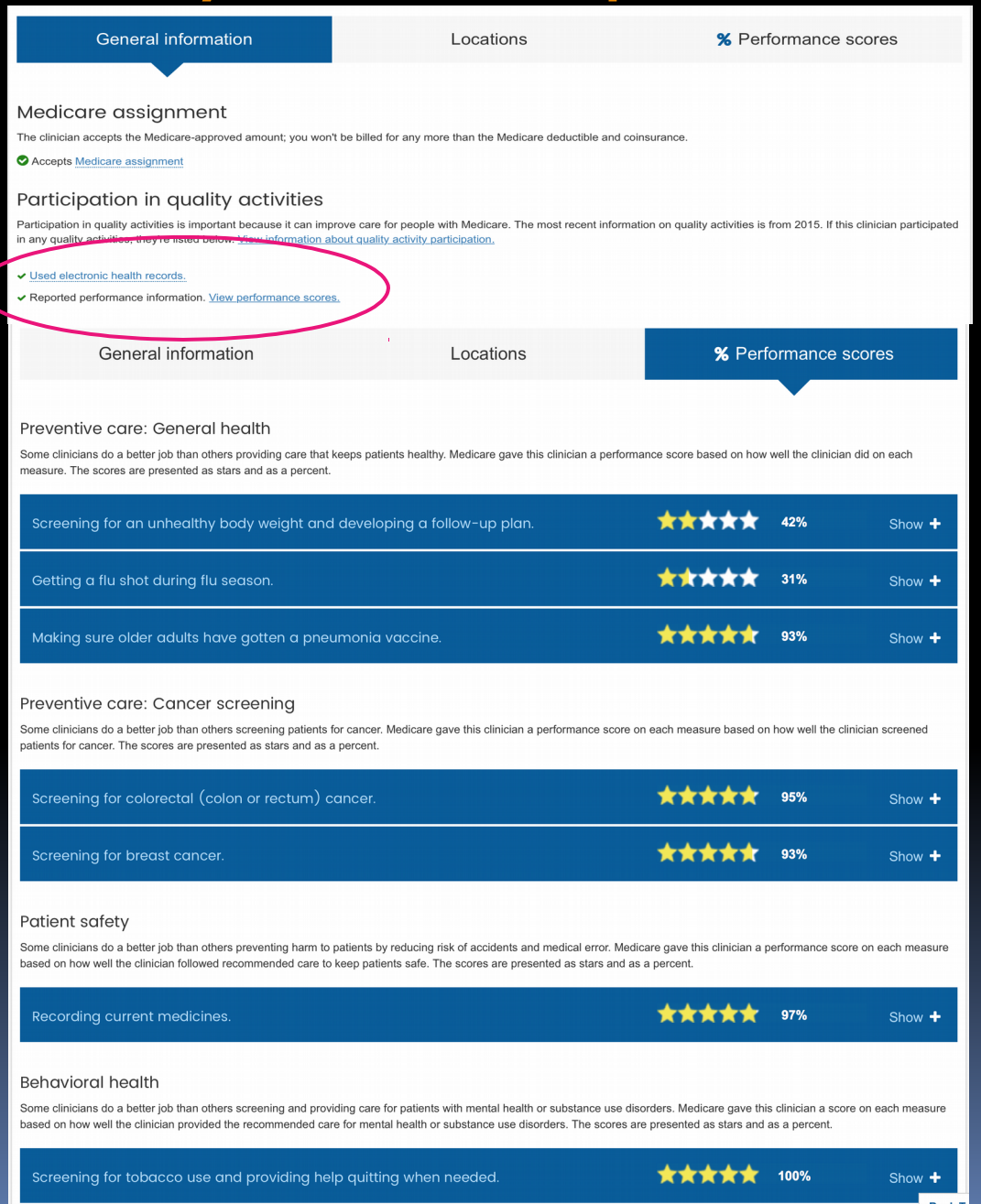
- Require use of certified EHR technology,
- Tie payment to certain quality measures comparable to those under MIPS, and
- Bear a certain amount of greater than nominal financial risk, or qualify as a Medical Home Model

Thresholds for Advanced APM Participants

Requirements for Incentive Payments for Significant Participation in Advanced APMs (Clinicians must meet payment or patient requirements)						
Performance Year	2017	2018	2019	2020	2021	2022 and later
Percentage of Payments through an Advanced APM	25%	25%	50%	50%	75%	75%
Percentage of Patients through an Advanced APM	20%	20%	35%	35%	50%	50%

* On June 20, 2017 CMS published a proposed rule for the 2nd year of the QPP that may change these thresholds in the 2018 performance year.

www.PhysicianCompare.com



General information | Locations | % Performance scores

Medicare assignment

The clinician accepts the Medicare-approved amount; you won't be billed for any more than the Medicare deductible and coinsurance.

Accepts Medicare assignment

Participation in quality activities

Participation in quality activities is important because it can improve care for people with Medicare. The most recent information on quality activities is from 2015. If this clinician participated in any quality activities, they're listed below. View information about quality activity participation.

- Used electronic health records.
- Reported performance information. View performance scores.

General information | Locations | % Performance scores

Preventive care: General health

Some clinicians do a better job than others providing care that keeps patients healthy. Medicare gave this clinician a performance score based on how well the clinician did on each measure. The scores are presented as stars and as a percent.

Screening for an unhealthy body weight and developing a follow-up plan.	42%	Show +
Getting a flu shot during flu season.	31%	Show +
Making sure older adults have gotten a pneumonia vaccine.	93%	Show +

Preventive care: Cancer screening

Some clinicians do a better job than others screening patients for cancer. Medicare gave this clinician a performance score on each measure based on how well the clinician screened patients for cancer. The scores are presented as stars and as a percent.

Screening for colorectal (colon or rectum) cancer.	95%	Show +
Screening for breast cancer.	93%	Show +

Patient safety

Some clinicians do a better job than others preventing harm to patients by reducing risk of accidents and medical error. Medicare gave this clinician a performance score on each measure based on how well the clinician followed recommended care to keep patients safe. The scores are presented as stars and as a percent.

Recording current medicines.	97%	Show +

Behavioral health

Some clinicians do a better job than others screening and providing care for patients with mental health or substance use disorders. Medicare gave this clinician a score on each measure based on how well the clinician provided the recommended care for mental health or substance use disorders. The scores are presented as stars and as a percent.

Screening for tobacco use and providing help quitting when needed.	100%	Show +

Physician Compare & MACRA

- Through MACRA's MIPS, clinicians will publically report clinician performance on a 100-point scale through four performance categories:
  - Quality
  - Cost
  - Improvement Activities
  - Advancing care information
- CMS will fold these metrics into a 5-star and percentage rating reflecting each provider's performance scores and will post them on Physician Compare within 15 months of the reporting deadline.

www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/physician-compare-initiative/

Physician Compare datasets

The Centers for Medicare & Medicaid Services (CMS) provides official datasets for the Medicare.gov Physician Compare website to give you useful information about groups, individual physicians, and other clinicians currently enrolled in Medicare.

- The **Physician Compare National Downloadable File** includes general information about individual eligible professionals (EPs), such as demographic information and Medicare quality program participation.
- The **Physician Compare 2015 Individual EP Public Reporting – Performance Scores** file contains measure performance rates for the 100 Individual EP 2015 Physician Quality Reporting System (PQRS) and 31 non-PQRS Qualified Clinical Data Registry (QCDR) measures reported via claims or registry that are available for public reporting. EP measure data is available for 180,723 individual EPs.
- The **Physician Compare 2015 Group Public Reporting – Performance Scores** file contains measure performance rates for the 112 group 2015 PQRS measures reported via the Web Interface or registry that are available for public reporting. Group measure data is available for 2,371 groups.
- The **Physician Compare 2015 Group Public Reporting – Patient Experience** file contains measure performance rates for the 8 Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS measures reported by groups that are available for public reporting. CAHPS for PQRS measure data is available for 429 groups.

Because only a sub-set of the measures are included, not all clinicians and groups that satisfactorily participated in PQRS and submitted quality measures will have measure data in these files. For more information about which measures are available for public reporting, visit the Physician Compare Initiative page.

Note: Because of data use agreements with data vendors, not all data on Physician Compare can be shared in the Physician Compare National Downloadable File. For more information about what is included in this database and how it differs from the information on the Physician Compare website, refer to the Downloadable Database Dictionary (under Get supporting documents).

Learn About Using Government Data

Announcements: **See less**

- 2015 measure data released in June 2017 with the completion of the Informal Review process. If you have any questions about the data, please contact the Physician Compare support team at PhysicianCompare@Westat.com.

DOWNLOAD CSV FLAT FILES (REVISED) NOW **GET ARCHIVED DATA**

Last updated on Jun 15, 2017

Showing: Physician Compare Sort by: Most Relevant

Name	Popularity	Type	RSS
Physician Compare 2015 Group Public Reporting - Patient Experience Consumer Assessment of Healthcare Providers and Systems (CAHPS) for PQRS measure performance rates reported by groups.	657 views		
Physician Compare 2015 Group Public Reporting – Performance Scores Physician Quality Reporting System (PQRS) measure performance rates reported by groups.	559 views		
Physician Compare 2015 Individual EP Public Reporting – Performance Scores Physician Quality Reporting System (PQRS) and non-PQRS Qualified Clinical Data Registry (QCDR) measure performance rates reported by clinicians.	659 views		
Physician Compare National Downloadable File The Physician Compare National Downloadable File is organized at the individual eligible professional level; each line is unique at the professional/enrollment record/Group Practice/address level. Professionals with multiple Medicare enrollment records and/or single enrollments linking to multiple practice location addresses are listed on multiple lines.	50,285 views		

Showing 4 of 4

FINAL PHYSICIAN FEE SCHEDULE (PFS)

2017

Calculation of the CY 2017 PFS Conversion Factor

CY 2016 Conversion Factor		**35.8043**
Update Factor	0.50% (1.0050)	
CY 2017 RVU Budget Neutrality Adjustment	-0.013% (0.99987)	
CY 2017 Target Recapture Amount	-0.18% (0.9982)	
CY 2017 Imaging MPPR Adjustment	-0.07% (0.9993)	
CY 2017 Conversion Factor		**35.8887**

Sequestration Extended

- The across-the-board sequestration of Medicare payments has been extended into fiscal year 2025.
- Under current law, Medicare payments for all items and services including Part B drugs will be reduced 2% through 2023, and then 4% for the first six months of 2024.

Non-face-to-face Prolonged Service Codes

- CMS finalized their proposal for separate payment for non-face-to-face prolonged service codes, 99358 & 99359. CMS adopts the CPT code descriptors and prefatory language for reporting these services and will follow CPT guidance that allows the prolonged time to be reported on a different day than the companion code. CPT 99358 is not an add-on code. It can be reported on a day when no other service is provided. CPT 99359 is an add-on code to CPT 99358.
- Time counted towards CPT codes 99358 and 99359 describe services "furnished during a single day directly related to a discrete face-to-face service that may be provided on a different day, provided that the services are directly related to those furnished in a face-to-face visit."
  - Prolonged service codes 99358 and 99359, cannot be reported during the transitional care management (TCM) 30-day service period by the same practitioner who is reporting the TCM (CPT codes 99495 and 99496).
  - Complex CCM (CPT codes 99487-99489) services cannot be reported during the same month as prolonged service codes 99358 and 99359, when reported by a single practitioner.
- Addendum B of the final rule shows the 2017 unadjusted national non-facility rate for CPT 99358 is approximately $113.41 and the non-facility rate for CPT 99359 is approximately $54.55.

CPT Code	Medicare Unadjusted National Rate
99358	$113.41
99359	$54.55

Chronic Care Management (CCM)

- New code G0506- Comprehensive assessment of and care planning for patients requiring chronic care management services (list separately in addition to primary monthly care management service)
  - This new code is an add-on code to provide extra payment for extensive initiating services by the CCM practitioner
  - Medicare national unadjusted payment rate is $63.88

Summary of CCM Coding Changes

BILLING CODE	PAYMENT (NON-FACILITY RATE)	CLINICAL STAFF TIME	CARE PLANNING	BILLING PRACTITIONER WORK
CCM (CPT 99490)	$43	20 minutes or more of clinical staff time in qualifying services	Established, implemented, revised, or monitored	Ongoing oversight, direction, and management Assumes 15 minutes of work
Complex CCM (CPT 99487)	$94	60 minutes	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 26 minutes of work
Complex CCM Add-On (CPT 99489, use with 99487)	$47	Each additional 30 minutes of clinical staff time	Established or substantially revised	Ongoing oversight, direction, and management + Medical decision-making of moderate-high complexity Assumes 13 minutes of work
CCM Initiating Visit*	$44-$209	--	--	Usual face-to-face work required by the billed initiating visit code
Add-On to CCM Initiating Visit (G0506)	$64	N/A	Established	Personally performs extensive assessment and CCM care planning beyond the usual effort described by the separately billable CCM initiating visit

www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/ChronicCareManagement.pdf

Summary of CCM Services Changes

CCM Requirement	Changes for 2017
Initiating Visit	• Now only required for new patients or patients not seen within 1 year prior to commencement of CCM • Extra payment for extensive initiating services by the CCM practitioner (G0506)
Certified EHR and other electronic technology requirements	• Certified EHR still required to standardize formatting in the medical record of core clinical information (demographics, problems, medications, medication allergies), but certified technology no longer required for other CCM documentation or transitional care management documents • No specific technology requirements for sharing care plan information electronically within and outside the practice, and fax can count, as long as care plan information is available timely (meaning promptly at an opportune, suitable, favorable, useful time) • Individuals providing CCM after hours no longer required to have access to the electronic care plan, as long as they have timely information • Remove standards for formatting and exchanging/transmitting continuity of care document(s) • Continue to encourage and support the use of certified technology and increased inter-operability, but code-level conditions of Medicare Physician Fee Schedule (PFS) payment may not be the best means of accomplishing this. Practitioners are likely to transition to advanced electronic technologies due to incentives of the Quality Payment Program, independent of CCM rules.
Continuous Relationship with Designated Care Team Member	• Improved alignment with CPT language for administrative simplicity
Comprehensive Care Management and Care Planning	• Improved alignment with CPT language for administrative simplicity and appropriate caregiver inclusion • No longer specify format of the care plan copy that must be given to the patient (or caregiver if appropriate) • Electronic technology use standards relaxed (see above)
Transitional Care Management	• Improved alignment with CPT language for administrative simplicity • Clinical summaries used in managing transitions renamed "continuity of care document(s)" • Electronic technology use standards relaxed (see above)
24/7 Access to Address Urgent Needs	• Improved alignment with CPT language • Clarifying the required access is for urgent needs
Advance Consent	• Verbal instead of written consent is allowed (but must still be documented in the medical record, and the same information must be explained to the patient for transparency)

New Code in 2017 - 96377

Code 96377 has been added to the CPT® 2017 code set in the Medicine/Therapeutic, Prophylactic, and Diagnostic Injections and Infusions subsection of the CPT code set.

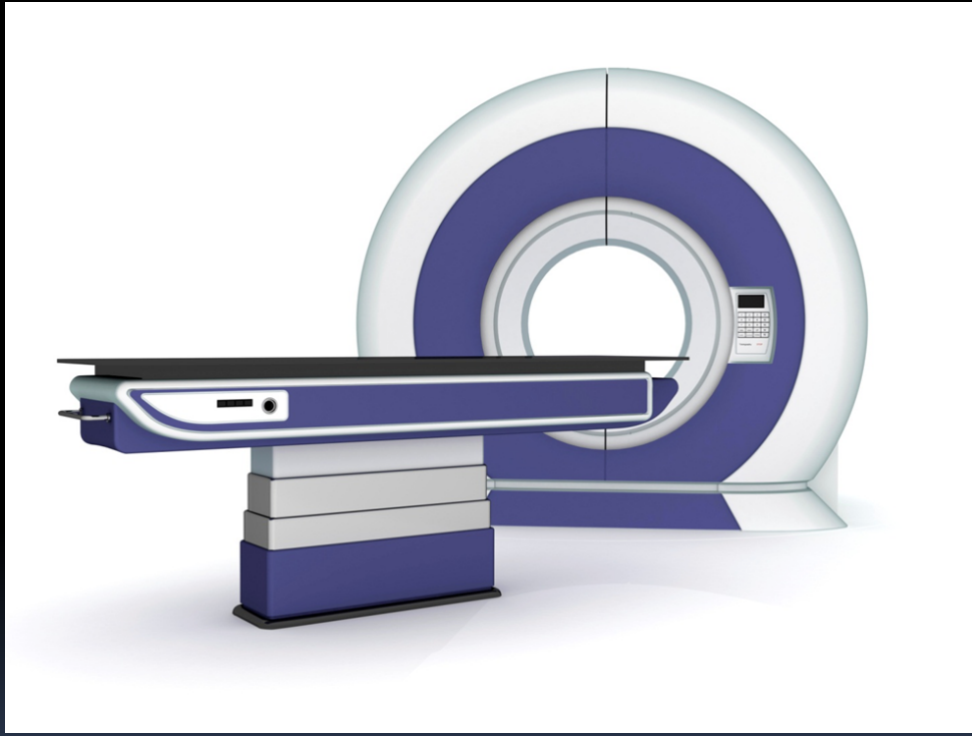
CPT 96377 *Application of on-body injector (includes cannula insertion) for timed subcutaneous injection*

96377 describes the work of preparing and applying the on-body injector to administer the drug subcutaneously.

96377 is not payable by Medicare – use 96372 to report the administration of Neulasta Onpro® to Medicare

Some commercial payers are paying on this code.

Since 2013, CMS has applied the Multiple Procedure Payment Reduction Policy (MPPR) to advanced imaging services furnished to the same patient, in the same session by a single or multiple physicians in the same group practice.



MPPR In 2017:
5% MPPR to the professional component (PC)
down from 25% in 2016
50% MPPR on the technical component (TC)

Part A/B Medicare Fee-for-Service Recovery Audit Program

- On October 31, 2016 the Centers for Medicare & Medicaid Services (CMS) announced the new Recovery Audit Contractors (RACs) for Medicare Fee for Service (FFS):
- Region 1 Performant Recovery Services
- Region 2 Cotiviti LLC (formerly known as Connolly Consulting)
- Region 3 Cotiviti LLC
- Region 4 HMS Federal Solutions
- Region 5 Performant Recovery Services

Recovery Audit Program - Changes

- The new look-back period is limited to six months from the date of service for patient status reviews when the hospital submits the claim within three months of the date of service (down from the previous look-back period of three years).
- The look-back period remains up to three years for other provider services.
- The RACs now have 30 days to complete complex reviews and notify providers of their findings (previously RACs had 60 days to complete these reviews).
- In the past, the RACs were paid immediately upon denial and recoupment of the claim, under the new contracts the RACs will not receive a contingency fee until after the second level of appeal is exhausted.
- RACs will be required to maintain an overturn rate of less than 10% at the first level of appeal, excluding claims that were denied due to no or insufficient documentation or claims that were corrected during the appeal process. Failure to maintain the overturn rate of less than 10% will result in CMS placing the RAC on a corrective action plan.

Billing Wasted Drug

- Effective January 1, 2017, CMS requires the use of the modifier JW to identify unused drugs or biologicals from single use vials or single use packages that are appropriately discarded.
- This modifier, billed on a separate line, will provide payment for the amount of discarded drug or biological.
- For example, a single use vial that is labeled to contain 100 units of a drug has 95 units administered to the patient and 5 units discarded. The 95 unit dose is billed on one line, while the discarded 5 units shall be billed on another line by using the JW modifier. Both line items would be processed for payment. Providers must record the discarded amounts of drugs and biologicals in the patient's medical record.

Medicare Claims Processing Manual Chapter 17 - Drugs and Biologicals, 40 - Discarded Drugs and Biologicals

2017 FINAL RULE

Hospital Outpatient Prospective Payment System (OPPS) Updates

OPPS Payment Rates

- Effective January 1, 2017, CMS increased the payment rates under the OPPS by an Outpatient Department (OPD) fee schedule increase factor of 1.65%.
- Continuation of 2% payment reduction for hospitals failing outpatient quality reporting requirements.
- Continuation of 7.1% Rural Hospital adjustment and Cancer Hospital adjustments (does not include drugs and devices).

OPPS Physician Administered Drugs

- Most physician administered drugs will continue to be paid at ASP plus 6%.
- In 2017, drugs amounting to $110 or less per encounter, by CMS calculation, will be bundled and will not be paid separately. This is up from $100 in 2016.
- Radiopharmaceuticals also have a $110 packaging threshold.

New CPT Code 96377

- CPT 96377 *Application of on-body injector (includes cannula insertion) for timed subcutaneous injection*
- 96377 describes the work of preparing and applying the on-body injector to administer the drug subcutaneously.
- Assigned Status Indicator N (Items and Services Packaged into APC Rates), payment will be included in the payment for the primary service reported.

Section 603 – Bipartisan Budget Act of 2015

- Under (Section 603), effective January 1, 2017, Medicare payments for most items and services furnished at an "off-campus" department of a hospital that was not billing as a hospital service prior to November 2, 2015, will be made under the Medicare Physician Fee Schedule (MPFS) or Ambulatory Surgery Centers (ASCs) fee schedule and eliminates their ability to charge a facility fee.
  - "Off-campus" is defined as a physical area located more than 250 yards from the main hospital campus building or a remote location of the hospital.

- The "site neutrality" provision begins to address concerns that Medicare should not be paying different amounts for the same services based on the location or type of provider, and that hospitals may be improperly incentivized to acquire and label physician practices and ambulatory surgery centers (ASCs) as hospital outpatient departments due to higher rates available for services furnished in hospital outpatient settings.

Section 603: Excepted Items & Services

- Excepted items and services furnished after January 1, 2017:
  - By a dedicated emergency department,
  - In a provider based department (PBD) that is "on the campus," or within 250 yards, of the hospital or a remote location of the hospital, or
  - By an off-campus PBD that was billing for covered outpatient provider department (OPD) services furnished prior to November 2, 2015, or in a temporary or permanently new location upon demonstration of extraordinary circumstances outside of the hospital's control, such as natural disasters, significant seismic building code requirements, or significant public health and public safety issues.

Site Neutrality Modifiers - 2017

- Modifier PN: Non-excepted service provided at an off-campus, outpatient, provider-based department of a hospital.

- Modifier PO: Excepted service provided at an off-campus, outpatient, provider based department of a hospital.

Resources

- 2017 Physician Fee Schedule Final Rule:

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1654-f.html2017

- 2017 Hospital Outpatient Final Rule:

  https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices.html

Resources

- CMS QPP Website
  https://qpp.cms.gov

- CMS QPP Webinar

https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Quality-Payment-Program-Long-Version-Executive-Deck.pdf.

- CMS Proposed Rule - Medicare Program; CY 2018 Updates to the Quality Payment Program
  https://s3.amazonaws.com/public-inspection.federalregister.gov/2017-13010.pdf

THANK YOU