Medical Billing Professionals Support Suite

IMPORTANT: Medicare's New MACRA Quality Payment Program

2016-12-27 - Medical Billing Professionals - Comments (0) - General

Medicare's New MACRA Quality Payment Program

All providers should by now know that Medicare will be moving from a fee for service reimbursement system to a value based program. Under MACRA's Quality Payment Program, providers will be required to report quality measures in order to ensure that providers receive either an increase in payment or at least a neutral adjustment.

Most providers will be under MIPS: the Merit-based Incentive Payment System.

WHO MUST REPORT:

- Providers who bill at least $30,000 in allowed charges per year to Medicare OR who see at least 100 different Medicare patients per year must report
- It is important to understand in the above that the $30,000 minimum amount is based on the allowed amount from Medicare, NOT what you bill.
- As an example, let's say Medicare allows $30 for a 98940 code. That would equate to 1000 visits for the year to equal $30,000 in allowed charges (or approximately 20 Medicare visits per week)
- All DCs, MDs, DOs, NPs must report beginning in 2017.
- PTs do not have to report in 2017 (but presumably will have to report in 2018)
- It is also important to understand that this only applies to Medicare Part B. The QPP does NOT apply to Medicare Advantage HMO Plans and does not apply to commercial payers. This only applies to patients who have traditional Medicare Part B.

HOW WILL IT AFFECT YOUR REIMBURSEMENT:

- Data reported in 2017 will affect their 2019 reimbursements (data reported in 2018 will affect 2020 reimbursements, etc).
- Because 2017 is the first year of reporting, providers have 3 options: full year of reporting, partial year (90 days) of reporting or no reporting.
- For providers who report quality measures for the entire 2017 year, you will receive in 2019 up to the maximum of a 4% positive adjustment.
- For providers who report 90 days of measures in 2017, you will receive in 2019 either a small positive adjustment or a neutral adjustment
- For providers who report minimum data during 2017 (such as only one quality measure per visit), you will have a neutral adjustment in 2019.
- For providers who do not report any measures in 2017, you will receive a -4% negative adjustment for your payments in 2019.

HOW CAN YOU REPORT:

- Providers can report through a registry, through most EMRS that are certified for meaningful use OR by claims-based reporting
- For providers who report via claims-based reporting, it is our understanding that you will use existing PQRS codes (such as G8539, G8742, etc) to report.
- HOWEVER, unlike PQRS where providers generally reported only 2 measures, it is the recommendation of some coding experts that providers under MACRA will have to report more measures (and thus more codes) under claims-based reporting.
- For providers who choose claims-based reporting, you would simply indicate the appropriate CPT codes like G8539 and G8742 on the billing log with the other CPT codes being billed for a patient.
- FOR EXAMPLE, for John Smith for 1/3/17, you may want to report 98940-AT, G8539, G8730 or 98940-AT, G8942, G8730). Again, though you may need to report more than the 2 measures indicated here.
- For providers who are submitting billing to us via an EMR program like EZNotes, Amazing Charts or Practice Fusion, you must select the appropriate codes (like G8539, G8730, G8942) in your program so they appear on the billing report you provide to us.

SHOULD YOU REPORT?

- It is up to all providers to determine if it is worth complying with the new MACRA QPP reporting requirements.

- As an example, if Medicare allows currently $35 for a 98941 and you do not report, you would be subject to a 4% penalty in 2019. That would equal $1.40 per visit. Some providers may decide it is worth being paid $1.40 less per Medicare visit rather than having to comply with MACRA's QPP.
- It is your responsibility to report the codes to us for billing. If you do not report the necessary claims-based codes to us, we will be submitting the claims as you submit to us (without the PQRS codes). Remember, if you DO want to comply, you will be reporting the codes on EVERY visit for your patients.

RESOURCES:

- There is a lot that is still unknown about this program. Medicare does have information available about the breakdown of the new reporting requirements at https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-MIPS-and-APMs.html.
- Also check out: https://qpp.cms.gov/measures/quality.
- We also encourage providers to view Webinars that various companies offer.
- For our chiropractic clients, we recommend Dr. Marty Kotlar of Target Coding. Besides offering webinars, he also does seminars throughout the country and he does have a webinar on his You Tube Channel about the QPP: https://www.youtube.com/watch?v=vWoVtgGDZis.

Thanks,
Steve