Webinar Q&A: “Decoding the 2017 Medicare (CMS) Fee Schedule and MACRA Rule”

2017 (CMS) Fee Schedule questions:

Q. **Can we use the 60-minute critical care telemedicine code G0508 if time spent is less than 60 minutes?**
   A. According to CPT, a unit of time is attained when the mid-point is passed. For example, an hour is attained when 31 minutes have elapsed.

Q. **Will chemodenervation procedure codes be included in the global data collection period since those codes have a 10-day global period?**
   A. Yes, these codes will be included in the data collection as they have a designated number of post-procedural E/M encounters bundled into the reimbursement for the service. Unrelated E/M services within the 10-day global period are not subject to the data collection requirement.

Q. **Why is the reimbursement so low for my time providing prolonged services? My time should be worth the same whether I am seeing the patient or not. How was the work CPT factor determined?**
   A. The work Relative Value Units (or RVUs) used to calculate physician payment are established by CMS. Recognition of the non-face-to-face time associated with E/M services and advocating for increased reimbursement for cognitive care codes continues to be a priority of the AAN.

Q. **Does G0505 come into effect 2017 or is it in effect now?**
   A. The new codes will go into effect and be reimbursable January 1, 2017.

Q. **Can G0505 be used more than once in a year and can the code be applied to diagnosed and undiagnosed patients?**
   A. CMS did not specify a reporting period; however, the nature of the service does not support reporting the code multiple times in a year. If revising the care plan, it would be more appropriate to report one of the chronic care management codes. It will be important to review your local Medicare coverage policies after January 1 for any reporting limitations.

Q. **How much of the G0505 code needs to be face-to-face?**
   A. G0505 is a face-to-face service. Patient / caregiver questionnaires may be completed in advance; however, the relevant parts of the encounter must be provided face-to-face.

Q. **Can G0505 code be used for stroke patients with cognitive impairments or only patients with dementia?**
   A. Yes. Regardless of the cause of impairment, G0505 is ok to report for cognitive assessment and care planning, assuming all the required elements are met and the standardized instrument is appropriate for the condition.
Q. Does the stage of dementia make a difference in reporting G0505? For example, can I use the code for severe nursing home patients who come to see me?
A. CMS states G0505 is for assessing and creating a care plan for beneficiaries with a cognitive impairment, at any stage of impairment. The code can be reported in the office or other outpatient setting, home, domiciliary, or rest home.

Q. If I am performing a dementia consult, I might bill for a new patient encounter, (99204) along with 96120 and 96103. How does that compare or does one also consider adding the new code of G0505 if also discussing safety, driving, power of attorney issues, etc.?
A. In the Final Rule, CMS states that G0505 cannot be reported in conjunction with an E/M service, nor several other codes, including 96103 and 96120. To determine the appropriate code to report, review the required elements list developed by CMS. (For a full list of codes which cannot be reported with G0505 and a detailed list of the required elements, view the 2017 CMS Coding Table.)

Q. If G0505 is approved, can I code it every year to have an up-to-date care plan as the patient’s symptoms and diagnosis evolves? For example, a patient may get worse in year two and require different community resources and the diagnosis may change.
A. While CMS has not established a limit on the reporting period, the service was created with the intent that it would not be reported multiple times over the course of a beneficiary’s treatment. If revising the care plan, it would be more appropriate to report one of the chronic care management codes.

Q. How will a hospital-based neurologist be affected? Will the new codes and newly-reimbursable codes be usable inpatient?
A. This will depend on the services you report. Reimbursement for outpatient services and inpatient physician visits (under Medicare Part B) is established by the MPFS. Hospital based services are paid under the Outpatient Prospective Payment System (OPPS.)

MACRA questions:

Q. Are there any disadvantages in trying for the full-year reporting period in order to try to earn a small bonus, vs. the partial year (90 day) reporting?
A. There is no potential downside in terms of your MIPS adjustment score. If you report anything in 2017, you avoid the penalty, and the more you report (and presumably the better you do on the performance) the more likely you are to get a higher score. The risk that is built into pursuing that high performance is the cost to your practice to achieve that level of performance.
Q. If I fall into the low volume exclusion with less than 100 Medicare patients per year, how do I notify Medicare; is the exclusion automatic or do I have to ask CMS for the exclusion?
A. Medicare is calculating low-volume threshold (LVT) and notifying physicians of their status in December 2016 or shortly after January 1, 2017. For purposes of the 2019 MIPS payment adjustment (2017 performance year), CMS will initially identify the low-volume status based on 12 months of data starting from September 1, 2015, to August 31, 2016, with a 60-day claims run out. To account for the identification of additional individual eligible clinicians and groups who do not exceed the low-volume threshold during the 2017 performance period, CMS will conduct another eligibility determination analysis based on 12 months of data starting from September 1, 2016, to August 31, 2017, with a 60-day claims run out.

Q. For the 6 measures, do we need 20 patients for each measure?
A. You will need to report up to 6 quality measures, including an outcome measure or a high-priority measure, for a minimum of 90 days. Providers reporting on quality measures must report on at least 50% of their eligible Medicare and non-Medicare patients who are eligible for the measure. Each measure reported must have a minimum of 20 cases to be included in the Quality category score.

Q. If I have chosen not to use an EHR, in what parts of MACRA quality reporting could I still participate?
A. There are numerous incentives written into MACRA on both sides of the program for practices utilize to use not only EMRs but certified EMR / EHR technology. Certainly, for the advancing care information component, the score would be significantly/ negatively impacted by failing to do that. If the practice uses a non-EHR and non-registry reporting mechanism, such as through a web interface, there are opportunities to do manual reporting of the other domains. This involves a bit more work on the part of the practice to have the personnel in place, but is an option for those who can’t collect data through their EMR or who are not participating in a registry.

Q. Often neurology patients get progressively worse no matter how good the physician’s care. It seems as though CMS is not accounting for the reality of the neurologic patient. How is CMS looking at this when reviewing outcomes?
A. Most of the measures that are specialty relevant measures for neurology are process measures. In other words, the quality of care is determined by whether or not we do the things that are considered to be representative of high quality of care. This is where the important tools that CMS has in terms of patient attribution come into play; if a patient has a good or bad outcome, to which provider is that outcome attributed? The other principle is risk adjustment; looking at the composition of patients of a given practice to see how well those patients do versus or compared to how well you would expect them to do. The concern for neurology will become more relevant at a time when the majority of those measures are outcome measures and if they are attributed to that neurologist.
Q. Would a neurology APM be able to be restricted to neurologists in a distributed network?
A. Neurology-specific APMs are still being developed and will need to be approved and tested. For 2017, the following “Advanced APMs” have been approved by CMS under the Quality Payment Program:
- Comprehensive ESRD Care Model (Large Dialysis Organization (LDO) arrangement)
- Comprehensive ESRD Care Model (non-LDO arrangement)
- CPC+
- Medicare Shared Savings Program ACOs - Track 2
- Medicare Shared Savings Program ACOs - Track 3
- Next Generation ACO Model
- Oncology Care Model

Q. Is there a list of neurologic-specific measures? If so, where can I find them?
A. Yes, use CMS’s Quality Measures Search Tool and select “neurology” from the “Specialty Measure Set” drop down menu.

Q. We are an office with 2 providers. In the past, each physician qualified individually. I have heard that a group of 2 or more with same TIN and different NPI must report as a group and cannot report individually. Is that true?
A. MIPS-eligible clinicians have the flexibility to submit information individually or as a group. Groups have the option to report at the individual (TIN/NPI) level or the group (TIN) level. Depending on the composition of a group, you may find reporting at the individual level to be more advantageous for the group than reporting at the group level and vice versa.

Q. With MACRA, under MIPS, was there additional leniency provided to small groups of less than 5 providers of what will be required?
A. In the law, few alternative payment models exist for specialists like neurologists, and CMS is charged with ensuring the development of specialty-relevant APMS, which would be useful for neurologists in small or solo practice. There is also a broad recognition that the implementation impact is much higher for practices that are solo practices or small groups. For the MIPS pathway, solo practices or small groups (which CMS defines as fewer than 15 providers) will receive double points for their improvement activities. In other words, they can do half the number of improvement activities and still receive the full score. There are also quality domain adjustments based on all cause readmission for attributed patients, which small practices are excluded from. In addition, if you are a hospital-based neurologist you don’t have much control over your EMR, therefore for those neurologists the contribution of the ACI component of MIPS is not attributed or assigned to that provider by CMS.

Q. I note on the CMS site that the prior dementia group for PQRS had 6 or more measures that could meet the entire PQRS requirements. The new one on the AAN site has only 2 in the dementia group meaning one must use more categories. Do those changes occur for 2016 or 2017 reporting?
A. The upcoming reporting period and changes related to the MACRA Quality Payment Program is for the calendar year reporting in 2017. Any bonuses or penalties will be applied in 2019.
Q. How will we find out about benchmarks?
A. Under the MIPS program, providers must now demonstrate improved quality above a baseline level. For the 2017 performance year, CMS will set a baseline performance benchmark based on 2015 performance data. Providers will be scored on performance in the first year, but will have to demonstrate improvement in later years. Benchmarks will be based on the performance period and will use deciles. Deciles will then be assigned points to calculate the providers score. CMS plans to release specific benchmarks for each measure prior to the start of the performance period. For more information visit the CMS Quality Payment Program Education & Tools page.