Primary care physicians will be the biggest beneficiaries of the 2017 Medicare Physician Fee Schedule (PFS), according to an analysis of the PFS proposed rule by The OrthoActivist. Orthopaedic practices can still look forward to better reimbursement for imaging services thanks to a proposal to boost RVUs to account for digital image processing, among other changes.

Overall payments will remain stable – the proposed rule sets the 2017 conversion factor at $35.7751, which is down from the current 2016 conversion factor of $35.8043. This change, which essentially keeps Part B payments flat, is mandated by the budget neutrality requirements in the Medicare Access and CHIP Reauthorization Act (MACRA), the law that repealed the longstanding Medicare payment formula known as the Sustainable Growth Rate (SGR).

MACRA requires CMS to establish positive or flat payment updates from 2016 through 2019, at which point the Merit-Based Incentive Program (MIPS) will begin to adjust payments based on provider performance.

Now let’s take a look at the highlights of the 856-page proposed rule, which CMS released on July 7.

- Flat payment update. As mentioned above, the 2017 conversion factor is projected to be $35.7751, which is essentially flat and continues the series of minor payment updates CMS is required to establish as part of MACRA.

- Increased RVUs for imaging. CMS wants to rework practice expense relative value units (RVUs) for imaging services (CPT codes in the 70000 range) to account for the cost of a picture archiving computer workstation, as well as the time associated with reviewing and scanning images. A total of 426 codes would have their practice expense RVUs modified under the proposed rule, though the
actual RVU and payment changes are not specified and CMS is asking for feedback on the "standard time" it takes to scan and review images on workstations.

- **Global surgical data-gathering.** CMS was committed to turning all codes that currently have 10-day and 90-day global periods into 0-day global codes, a change finalized in the 2015 PFS. However, the MACRA law required CMS to first gather data on post-surgical visits so the agency could accurately value these codes. Thus for the 2017 PFS, CMS is proposing to collect data via claims along with a representative survey of 5,000 randomly sampled providers. All providers that currently perform services with 10-day and 90-day global periods will be required to report additional information on those claims about all services rendered during the global periods. This will be mandatory and while CMS won’t withhold payments from providers who fail to participate, the agency warns it is authorized to withhold up to 5% of Medicare payments and could implement this in a future rule if participation rates aren’t high enough.

- **New Medicare Advantage enrollment rules.** CMS wants to require all providers who participate with Medicare Advantage plans to be subject to its enrollment and revalidation process. This would affect only those providers who are currently non-par with Medicare but do participate with private-payer Medicare Advantage (Part C) plans.

- **Primary care pay boost.** CMS aims to increase payment for primary care services in several different ways with the proposed rule. First, the agency proposes increased payment for the existing chronic care management (CCM) codes, along with two new CCM codes for complex cases where patients require extra management. Orthopaedists are eligible to report CCM codes and would benefit from this proposal if they specifically treat relevant chronic conditions such as arthritis and osteoporosis, though the codes are only reportable once per month per beneficiary.

- **Prolonged services.** Related to the above bullet, CMS proposes increasing payment for existing prolonged service E/M codes (CPT 99354-99357) and also adding new prolonged service codes for non-face-to-face evaluation and management.

- **Mobility-related disability code.** CMS wants to create a new HCPCS code, GDDD1, that can be billed for E/M encounters where the patient has a mobility-related disability that increases the amount of time the physician must spend with the patient (e.g. moving the patient over stairs or other obstacles). This code would have roughly the same RVUs and payment as a level established patient visit (99212). Though again aimed at primary care providers, orthopaedists could benefit from this code since they are also likely to see patients with mobility issues.

**Final rule expected this fall**
You have until Sept. 6 to submit any comments to Regulations.gov during the public comment period for the proposed 2017 PFS. Typically CMS releases the PFS final rule at the end of October or during the first week of November.

**Proposed OPPS/ASC rule offers 90-day EHR reporting**
You would only have to report meaningful use measures from your electronic health record (EHR) for 90 days in 2016 instead of the full year if CMS’ proposed Outpatient Prospective Payment System and Ambulatory Surgical Center (OPPS/ASC) rule for 2017 is finalized.

The meaningful use proposal would apply to all eligible providers, including critical access hospitals (CAHs), and means any contiguous 90-day period between Jan. 1, 2016 and Dec. 31, 2016, could be used for reporting. “We believe it would continue to assist healthcare providers by increasing flexibility in the program,” CMS stated in a fact sheet accompanying the proposed rule, which dropped July 6.

This provision is the biggest in an otherwise uneventful proposed rule for orthopaedists. Below is a bullet-point list of other highlights from the 2017 proposed rule.

- **OPPS and ASC payment rates.** CMS proposes to update OPPS payments by 1.55%, and the agency estimates an overall 1.6% payment increase for hospitals paid under OPPS in 2017. For ASCs, the payments are updated annually based on increases to the Consumer Price Index for urban consumers. In 2017, CMS is projecting an overall 1.2% increase in ASC payments.

- **90-day meaningful use reporting period.** As mentioned earlier, the reporting period for 2016 is proposed to be any 90-day contiguous period for eligible providers. Additionally, CMS admits in the proposed rule that it would not be “technically feasible” for those eligible providers that have not successfully demonstrated meaningful use yet (i.e. new participants) to attest to the Stage 3 objectives and measures.
CMS proposes that these providers attest to modified stage 2 objectives and measures by Oct. 1, 2017.

• **EHR hardship exceptions.** For new providers – again those who have not yet attested to meaningful use – CMS is proposing a new hardship exception that would allow them to be exempt from the 2018 payment adjustment. These providers would be required to transition to meaningful use reporting under the Merit-Based Incentive Payment System (MIPS) in 2017, under the MACRA proposed rule.

• **New ASC quality measures.** The existing Ambulatory Surgical Center Quality Reporting Program (ASCQR) would get seven new quality measures under the 2017 OPPS/ASC proposed rule. There is a new measure anesthesia and one for cataract surgery. The remaining five have to do with patient satisfaction and experience.

The OPPS/ASC final rule is typically released around the beginning of November.

### MIPS: Alternative Payment Models may boost ortho

You now know that Medicare will be consolidating all of its existing major incentive programs into a single entity called the Merit-Based Incentive Program (MIPS), but you may not know that there’s a way to avoid participating in MIPS entirely. The same law that created MIPS also establishes a second path to pay-for-performance called Alternative Payment Models (APMs), and participating in the right APM means you don’t need to worry about MIPS.

Previous issues of *The OrthoActivist* have discussed in detail how quality reporting and meaningful use will change under MIPS, as well as how the overall MIPS program works on a point system to determine positive or negative final payment adjustments. This article addresses APMs, which operate in tandem with MIPS but have gotten far less publicity. Part of the reason is that APMs also establishes a second path to pay-for-performance called Alternative Payment Models (APMs), and participating in the right APM means you don’t need to worry about MIPS.

What are APMs?

APMs refer to payment models that are pay-for-performance as opposed to the fee-for-service model that has long been the basis for Medicare payments. CMS defines two types of APMs: "Advanced APMs," which are considered eligible for complete exemption from MIPS, and "intermediate APMs," which includes all other APMs that don’t meet the Advanced criteria and thus do not allow providers to be exempt from MIPS.

Providers who are not participating in Advanced APMs, but are participating in other APMs, do receive some credit toward the MIPS program under one of the four MIPS components, clinical practice improvement activities. **Remember:** The MIPS components are quality, which replaces the Physician Quality Reporting System (PQRS), advancing care information, which replaces the meaningful use program, cost, which replaces the value-based payment modifier, and clinical practice improvement activities, which replaces the similarly-named clinical practice improvement initiatives. It’s not a huge boost, since the clinical practice improvement category can only account for 15% of the overall MIPS composite score that determines payment.

Participation in an Advanced APM is far more beneficial, and the payment bonuses are significant while the administrative burden is reduced since MIPS participation goes away. **Providers in an Advanced APM receive a positive 5% Medicare physician fee schedule update from 2019 through 2024.** For years 2026 and beyond, these providers are guaranteed to receive higher fee schedule updates than other non-participating providers. During all of these years, they do not have to participate in MIPS.

In the MACRA proposed rule, CMS identifies six existing APMs as advanced and 18 others as not advanced. The six **approved Advanced APMs** are:

- Comprehensive End-Stage Renal Disease (ESRD) Care
- Comprehensive Primary Care Plus
- Medicare Shared Savings Program, Track 2
- Medicare Shared Savings Program, Track 3
- Next-generation Accountable Care Organization (ACO) Model
- Oncology Care Model, two-sided risk arrangement

None of the existing ortho-specific APMs, such as Medicare’s BPCI and Comprehensive Joint Replacement (CJR) programs,
are on this list from the proposed rule. It’s possible that some orthopaedic practices are participating satisfactorily in either the Medicare Shared Savings Program or a next-generation ACO would already be eligible for the full Advanced APM payment track and exempt from MIPS, but most orthopaedists won’t qualify if the proposed rule is finalized as-is. Instead, the real benefit to orthopaedists will come if CMS agrees to classify APMs such as BPCI and CJR as being Advanced APMs.

Why orthopaedics could benefit

Some orthopaedic practices were already participating in the BPCI program, and many are now required to participate in the CJR program based on their location. While these programs are considered APMs, according to the proposed Medicare Access & CHIP Reauthorization Act of 2015 (MACRA) proposed rule, neither meet the Advanced APM criteria. Many organizations, including AAOE, have been advocating for CMS to certify or provide guidelines by which orthopaedic-specific models can be considered, as Advanced APMs. As proposed under MACRA, you will get additional points under MIPS’ clinical care improvement category for being in either BPCI or CJR, but you won’t be wholly exempt from MIPS.

Several BPCI models already meet several of CMS’s Advanced APM criteria, and some BPCI participants believe there’s a case to be made that several models meet all the criteria. “We firmly believe the basis exists for inclusion of this BPCI model as an Advanced Alternative Payment Model,” writes Jan Vest, CEO of Signature Medical Group, in a 10-page comment letter to CMS on the MACRA proposed rule. “Creating barriers to physician engagement in such models will not only be detrimental to the goal of CMS and Congress to preserve Medicare for current and future generations, it will deny beneficiaries the access to the kind of innovative care redesign that is already showing such promise in improving patient outcomes.”

CMS may delay MACRA, MIPS start date

You might get some extra time to prepare your providers for Medicare’s sweeping new Merit-Based Incentive Payment System (MIPS). MIPS is currently scheduled to begin modifying your 2019 Medicare payments based on performance data from 2017, which means that you have less than six months to get ready. But now CMS is hinting that a delay is possible, though the information is based on statements from the agency’s acting administrator.

“There has been significant feedback received here, and we remain open to options including alternative start dates, looking at shorter [reporting] periods used, and other ways physicians could get help and experience before the program hits them,” CMS Acting Administrator Andy Slavitt said during a July 13 televised Senate Finance Committee hearing on MIPS, which is a key component of the Medicare Access and CHIP Reauthorization Act (MACRA), passed last year. Slavitt said that CMS will take steps to ensure that MIPS “begins on the right foot, so every physician in the country feels that they are set up for success.”

Slavitt made these remarks under questioning from several skeptical members of the Committee, including Sens. Orrin Hatch (R-Utah), Ron Wyden (D-Ore.), and Robert Menendez (D-N.J.), all of whom referenced the volume of legislative changes providers and practices are facing as a result of the Affordable Care Act, the ICD-10 transition, and the switch to electronic health records.

As it stands, the MACRA proposed rule (released April 27) sets Jan. 1, 2017 as the date on which CMS begins data collection for 2019, the first MIPS payment year. The MACRA final rule is expected in early November, which would give practices even less time to prepare for any changes made in the final rule that don’t appear in the proposed rule.

If CMS decides to move the date back, it would probably have to shift all of the MIPS payment years. AAOE has asked for 90-day contiguous reporting periods in its comments on the proposed rule, and Slavitt’s remarks did make it clear that CMS is exploring this option. Either way, you will still need to educate your staff and providers on MIPS and stay on top of changes, which The OrthoActivist will help you to do.
CMS signals openness to change

While there’s no guarantee that CMS will certify BPCI models or CJR as Advanced APMs for MACRA purposes, the agency is making a public effort to stress that it’s open to feedback and change. “We are on the beginning of a journey to move toward a new set of models that ... give [providers] the flexibility to get reward for quality,” CMS Acting Director Andy Slavitt said during a Senate Finance Committee hearing on July 13. Slavitt emphasized that the current crop of APMs is open to change based on feedback, especially in the first few years of MACRA, and said the agency wants APMs that deliver better outcomes at lower cost while running “in the background” of the physician-patient interaction.

The full text of the MIPS proposed rule is available here. The public comment period officially ended on June 27 and the final rule is expected at the end of October or beginning of November.

Revenue growth: Efficiency in healthcare

Note: This is the second of a four-part series on improving your practice processes and workflow to boost revenue. The first article ran in the June 2016 issue of The OrthoActivist.

Negotiating better contracts would certainly be beneficial, but many practices, suffering from the “Eeyore syndrome” (named for the gloomy, anhedonic donkey in the Winnie-the-Pooh books), are unlikely to pursue this process because they haven’t assembled or reviewed the data to support their position and don’t want to spend time arguing with carriers for scraps. For example, conducting a cost analysis would allow a practice to see which procedures have a higher cost-to-collection ratio, enabling it to potentially negotiate carve-outs for those procedures. Bottom line? Increasing revenues using traditional methods often costs too much time and resources to make any net gain.

Key points

- Efficiency suggests the ability to do something well or reach a specified goal without wasting resources.
- Lean Six Sigma has emerged as the “horse and carriage” of process improvement for medical practices.

Efficiency is key in healthcare

The idea of profitability being tied to linear algebra actually is quite archaic and is not very applicable in a complex system, of which healthcare fully qualifies. See, in a linear system, a one-to-one relationship exists between the components, and it’s usually pretty easy to manage. In a complex system, we see a many-to-many relationship, and the idea of complexity itself is tied to these interrelationships between players.

Yet even with all of the complexities on the nonclinical side of practicing medicine, there remains a beacon of light. And the word of the day (or decade) that describes this beacon is efficiency. It’s a word that all of us know and probably use routinely, but far fewer of us actually recognize the power of this weapon in the battle against declining profitability and even fewer know how to wield it effectively. For our purposes, efficiency is the ability to do something well or reach a specified goal using the least amount of resources possible. It’s also the ability to achieve the same results with less resources or achieve more or better results with the same amount of resources.

Here’s a real-life example. A subclinical staff member escorts a patient to the exam room where, inter alia, she spends three minutes verifying questions the patient completed on your questionnaire while in the waiting room. Once completed, the physician enters and repeats the same process, spending another three minutes verifying the same questions already reviewed by the subclinical staff.

We asked the physician about the redundancy of the process, and he said that a speaker at a conference told him that this process would result in fewer errors with regard to the answers provided by the patient – a noble rationale that speaks to the heart of quality of care and, on the surface, seems like sound advice. In subsequent questioning, however, we discovered that the practice never measured the error rate before engaging in this redundant step, nor did it measure the error rate during this redundant step. So while the goal (reduce errors on intake forms) was commendable, the practice didn’t know whether a problem existed in the first place and had no way to know whether this additional step improved either the safety or quality of patient care.

We conducted a test on this process and couldn’t find a single occurrence in which a patient answered the questions
differently for the physician than for the subclinical staff member. We did, however, find instances in which the patient responded to the subclinical staff member differently than they had on the questionnaire they completed in the waiting room (a finding we attributed primarily to patients misinterpreting questions on the questionnaire that were later clarified by the subclinical staff). As a result, we advised the physician that, by eliminating the step in which he repeated the questioning, the practice could save three minutes per visit without negatively affecting the quality of care.

The physician replied, "My problems here go way beyond three minutes a visit." This statement is true if you only see a few patients a day, but this practice saw 80 patients a day, which translates to 240 minutes (or four hours) of wasted time per day. In an ideal scenario, we could easily convert those four hours into value, but in our real world, because a base set of constraints exists in any process, we would likely only be able to convert around 25%, or one hour, of that time. So if this practice sees about four patients per hour, with an average revenue of $116 per visit, this results in an additional $92,800 in revenue per year. And that’s just from one modification to one process. Think about the revenue opportunities you might be missing out on simply because of a few obscure steps in your work flow.

Next issue: We’ll look at key concepts and models for efficiency and process improvement, including Six Sigma and Lean.

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**Physician Practice Compliance Timeline**

*Deadlines, effective dates and other important milestones practices must track:*

<table>
<thead>
<tr>
<th>Year</th>
<th>Event</th>
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<tbody>
<tr>
<td>2016</td>
<td>• September 30 – The CMS grace period ends. For professional services provided on and after this date, Medicare claims must include the most specific ICD-10 codes in order to ensure payment.</td>
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<td>• October 1 – All payers, including private payers that have said they will follow CMS in offering a grace period, will now be free to implement stricter edits for ICD-10 codes.</td>
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<td>• End of October – CMS to release Medicare PFS 2017 final rule</td>
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<td></td>
<td>• November 1 – CMS will release the final rule implementing the MIPS program.</td>
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<tr>
<td>2017</td>
<td>• January 1, 2017 – The first performance monitoring year for the Merit-Based Incentive Payment System (MIPS) begins. Provider performance in 2017 will be used to determine payment adjustments, positive or negative, in 2019 – the first MIPS performance year.</td>
</tr>
<tr>
<td>2018</td>
<td>• September 30, 2018 – Provider participation in Models 2, 3, and 4 of the Bundled Payment for Care Improvement (BPCI) program ends for cohort I (participation began in October 2013).</td>
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