Basics of Billing and Coding, Bundled Payments and the Value Based Modifier
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Director of Payment and Practice Management

September 2016

Disclosures
- Nothing to Disclose

Goals and Objectives
- Understand current payment systems
- Describe how current payment systems contribute to future payment systems
- Identify elements to consider in episode based (bundled) payments
- Recognize how value (quality and cost) impacts your payments
Current Payment Methodology 1.0: The Basics

- What the Payer needed to know:
  - What services/procedures were provided
  - Why those services/procedures were provided
  - When those services/procedures were provided
  - Where those services/procedures were provided

Medicare Payment Formula - Anesthesia

- (Base units + Time units) * CF
  - Base unit: Value determined by complexity of care
    - Includes usual pre- and post-operative visits, administration of fluids and/or blood products and interpretation of non-invasive monitoring
    - Does not include placement of CVP, A-line, PA catheter, post-op pain procedures, TEE for diagnostic purposes
  - Time: Time spent providing anesthesia care
    - Begins when anesthesiologist begins to prepare the patient for anesthesia care in the OR or in an equivalent area and ends when the anesthesiologist is no longer in personal attendance, that is, when the patient is safely placed under post-anesthesia supervision
    - Reported in actual minutes and converted to units.
  - Conversion Factor: Dollar per unit
    - Geographically adjusted

Medicare Payment Formula – Resource Based Relative Value System (RBRVS)

- \( \left[ \left( \text{RVU}_{\text{work}} \times \text{GPCI}_{\text{work}} \right) + \left( \text{RVU}_{\text{pa}} \times \text{GPCI}_{\text{pa}} \right) + \left( \text{RVU}_{\text{li}} \times \text{GPCI}_{\text{li}} \right) \right] \times \text{CF} \)
  - Relative Value Units (RVU)
    - Work, Practice Expense and Professional Liability Insurance
    - RVUs are geographically adjusted per locale specific Geographic Price Cost Indices (GPCI)
  - Conversion Factor
    - Dollar amount allowed per unit
Example:

- Surgical Code: 35001
  - Direct repair of aneurysm, pseudoaneurysm, or excision (partial or total) and graft insertion, with or without patch graft; for aneurysm and associated occlusive disease, carotid, subclavian artery, by neck incision

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**Medicare Payment Formula - Anesthesia**

- Allowed Amount = (base units × time units) × CF
- Assume anesthesia time is 2.5 hours

<table>
<thead>
<tr>
<th>Base Units</th>
<th>Time Units</th>
<th>Base × Time</th>
<th>CF (Unadjusted)</th>
<th>Allowed Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>10</td>
<td>10</td>
<td>20</td>
<td>$21.99</td>
<td>$439.80</td>
</tr>
<tr>
<td>10</td>
<td>10</td>
<td>20</td>
<td>$21.25</td>
<td>$425.00</td>
</tr>
</tbody>
</table>
Arterial Line

- CPT Code 36620: Arterial catheterization or cannulation for sampling, monitoring or transfusion (separate procedure); percutaneous

Medicare Payment Formula – RBRVS

- \[ \left( \text{RVU}_{\text{work}} \times \text{GPCI}_{\text{work}} \right) + \left( \text{RVU}_{\text{pe}} \times \text{GPCI}_{\text{pe}} \right) + \left( \text{RVU}_{\text{pli}} \times \text{GPCI}_{\text{pli}} \right) \times \text{CF} \]

- Procedure CPT code 36620
  - (2016 RVU's and Wisconsin GPCIs)

<table>
<thead>
<tr>
<th></th>
<th>Non-facility</th>
<th>Facility</th>
</tr>
</thead>
<tbody>
<tr>
<td>RVU</td>
<td>1.000</td>
<td>1.000</td>
</tr>
<tr>
<td>GPCI Work</td>
<td>0.22</td>
<td>0.22</td>
</tr>
<tr>
<td>GPCI PE</td>
<td>0.30</td>
<td>0.30</td>
</tr>
<tr>
<td>GPCI PLI</td>
<td>0.546</td>
<td>0.546</td>
</tr>
<tr>
<td>Adjusted RVU</td>
<td>1.45</td>
<td>1.45</td>
</tr>
<tr>
<td>CF</td>
<td>1.45</td>
<td>1.45</td>
</tr>
<tr>
<td>Adjusted Amount</td>
<td>$35.80</td>
<td>$35.80</td>
</tr>
<tr>
<td>Allowed Amount</td>
<td>$51.91</td>
<td>$51.91</td>
</tr>
</tbody>
</table>

Current Payment Methodology 2.0: Value

- What is Value in Health Care?
  - “Achieving high value for patients must become the overarching goal of health care deliver with value defined as the health outcomes achieved per dollar spent.”
  - “Since value depends on results, not inputs, value in health care is measured by the outcomes achieved, not the volume of services delivered, and shifting focus from volume to value is a central challenge.”
  - “Since value is defined as outcomes relative to costs, it encompasses efficiency. Cost reduction without regard to the outcomes achieved is dangerous and self-defeating, leading to false ‘savings’ and potentially limiting effective care.”


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Current Payment Methodology 2.0: Value
- Quality
  - Physician Voluntary Reporting Program (PVRP)
  - Physician Quality Reporting Initiative (PQRI)
  - Physician Quality Reporting System (PQRS)
    - 2016 performance determines 2018 adjustment
- Cost
  - Value-based Payment Modifier

Value-Based Payment Modifier
- Based on TIN
- Budget neutral
- Quality and Cost Composite Scores
  - PQRS and CMS calculated measures on admissions/readmissions for certain chronic and acute conditions
  - Patient attribution methods driven by plurality of primary care
- 2016 performance determines 2018 adjustment

Value-Based Payment Modifier
- Phased – in approach starting in 2015
- For 2016 performance/2018 payment period
  - Groups of 10 or more EPs:
    - Upward, downward or neutral adjustment: -4% to +4X
  - Groups of 2-9 Eps and solo practitioners
    - Upward, downward or neutral adjustment: -2% to +2X
  - Groups of NPPs or NPP solo practitioners
    - Upward or neutral adjustment: 0% to +2X
- Maximum allowable negative adjustment if PQRS requirements not met
### 2018 Value Based Payment Modifier Adjustments

<table>
<thead>
<tr>
<th>Cost/Quality</th>
<th>Low Quality</th>
<th>Average Quality</th>
<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>0.0%</td>
<td>+2.0X</td>
<td>+4.0X</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-2.0%</td>
<td>0.0%</td>
<td>+2.0X</td>
</tr>
<tr>
<td>High Cost</td>
<td>-4.0%</td>
<td>-2.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Physicians, PAs, CNSs, and CRNAs in groups of 10 or more EPs

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<th>High Quality</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Cost</td>
<td>0.0%</td>
<td>+1.0X</td>
<td>+2.0X</td>
</tr>
<tr>
<td>Average Cost</td>
<td>-1.0%</td>
<td>0.0%</td>
<td>+1.0X</td>
</tr>
<tr>
<td>High Cost</td>
<td>-2.0%</td>
<td>-1.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

Physicians, PAs, CNSs, and CRNAs in groups of 2-9 EPs and Solo Practitioners

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<td>0.0%</td>
<td>+1.0X</td>
</tr>
<tr>
<td>High Cost</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
</tbody>
</table>

### Current Methodology 3.0: Bundled Payments

![Delivery and Payment Models – Private Sector Initiatives](image)

### 2011 vs 2015

![Delivery and Payment Models – Private Sector Initiatives](image)
Current Methodology 3.0: Bundled Payments

- Bundled Payment for Care Initiative (BPCI)

<table>
<thead>
<tr>
<th>Model 1</th>
<th>Retrospective</th>
<th>Inpatient Hospital Services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Model 2</td>
<td>Retrospective</td>
<td>VP Hospital Services Professional Services Post-Acute Care Related Readmissions</td>
</tr>
<tr>
<td>Model 3</td>
<td>Retrospective</td>
<td>Post-Acute Care Related Readmissions</td>
</tr>
<tr>
<td>Model 4</td>
<td>Prospective</td>
<td>VP Hospital Services Professional Services Related Readmissions</td>
</tr>
</tbody>
</table>

- Participants select from list of applicable conditions
- Bids include discounts to Medicare program

Current Methodology 3.0: Bundled Payments

- Oncology Care Model (OCM)
  - Begins Spring 2016
  - Covers chemotherapy/related care for 6 months
  - Practices makes 5 year commitment
  - Practice Transformation
    - e.g., 24/7 access, EHR, continuous quality improvement, care plans
  - Encompasses Medicare FFS and other payers
  - Payment
    - FFS and $160 PBPM and Retrospective performance-based payment
    - Cost and quality
  - One and two-sided risk options

Current Methodology 3.0: Bundled Payments

- Comprehensive Care for Joint Replacement (CJR)
  - Lower Extremity Joint Replacement
    - DRGs 469 and 470
  - Mandatory in 67 selected Medicare Metropolitan Statistical Areas (MSA)
    - 800 hospitals
  - Regulatory Timeline
    - Final Rule – November 2015
    - Starts April 1, 2016
  - Originally not eligible for Advanced APM status under MACRA but CMS may revise that in Final Rule
Current Methodology 3.0: Bundled Payments

- In The Pipeline:
  - Cardiac Rehab
    - CMS-5519-P Medicare Program; Advancing Care Coordination Through Episode Payment Models (EPMs): Cardiac Rehabilitation Incentive Program Model; and Changes to the Comprehensive Care for Joint Replacement Model (CJR)
  - Maternal Care
    - Modern Healthcare, August 2016

Definition

“A single predetermined payment to multiple providers for an entire episode of care”

The Bundled Payment Guide for Physicians
©2014 Smith, Anderson, Blount, Dorsett, Mitchell& Jernigan, LLP
Who?
- Physicians
- Hospitals
- Employers
  - Boeing and Lowe's
- Payer(s)
  - Medicare Demonstrations
  - Medicaid Initiatives
  - Private Payer Programs

What?
- Episode/Procedure
  - Typical patient
    - Outliers – define, reduce, exempt
    - Typical clinical pathway
    - Volume
    - Data
- Episode or disease based?
  - Joint replacement/Cardiac/Urologic
  - ESRD/Oncology/Cardiac
- Services
  - Just the Procedure
  - I/P and/or Post Acute Care
  - All Part A and/or All Part B

When?
- When does episode begin
  - Admission?
  - Defined period prior to admission?
- When does episode end?
  - Discharge from operative setting?
  - Defined interval post discharge?
How?
- Retrospective or Prospective
  - Retrospective
    - Payments issued per fee schedule
    - Total spend compared to a pre-determined target
    - Post-episode reconciliation
  - Prospective
    - Payment based on per-determined amount
      - Example: DRG’s
- Risk
  - One-sided
  - Two-sided

Other Considerations
- Payment vs. Cost
- Claims data
- Technology
  - Avoid work arounds
- Complications and Re-do’s
- Quality and outcome metrics
- Spill-over effect
  - Impact on FFS revenue

Bundled Payment Basics
Costs < Bundled Amount < Current FFS

Episode bundles are constructed of individual services
Build Your Own Episodes
- Revenue vs costs
- Economics 101 and 201
- Use of your practice’s data
- Tools
- Models
- PSH

"Off the Shelf"
- CMS Method A Episode Grouper for Medicare (EGM)
  • Claims Data
  • Episode Construction

CMS Method A Episode Grouper for Medicare (EGM)
- Episode shells
  • Start date
  • End date
  • Type of episode
Targeted Percentage of Medicare FFS Payments Linked to Quality and Alternative Payment Models: 2016 and 2018

Current Systems Impact on Future Systems

- Accuracy of current values
  - Resources
  - Relativity
- Conversion Factor
- Risk

CPT Process

1. Submit a CPT Code Change Proposal
2. AMA Staff Review
3. CPT/HCPAC Advisory Committee Review
4. Present to CPT Editorial Panel (accept/table/postpone/reject)
**RUC Process**

- New or Revised CPT code
- OR
- Review initiated by RUC and/or CMS
- Specialty Society Level of Interest
- Surveys
- RUC Presentations

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**The Centers for Medicare & Medicaid Services (CMS)**

- Receives/reviews RUC recommendations
- Publishes its proposed values in the Proposed Rule for the upcoming year Medicare Physician Fee Schedule
  - Typically published in early July
  - Considers all comments received from any interested party
- Publishes decisions in Final Rule on Medicare Physician Fee Schedule
  - Typically published in early November

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**Percentage of Work RVUs ≥ RUC Recommendations**

Source: 2016 Medicare RBRVS, AMA
“The Department of Health and Human Services categorization of payment methods acknowledges that most value-based physician payment models being tested are built on top of the MPFS, as are the two value-based payment initiative that replaced the sustainable growth rate formula – the Merit-Based Incentive Payment System and Alternative Payment Models. If the foundation of Medicare’s fee schedule isn’t sound, these systems will be unstable.”


Erosion of Fee for Service

Conversion Factor
Target for Relative Value Adjustments for Misvalued Services

- Separate from Budget Neutrality Adjustment
- Background:
  - The Protecting Access to Medicare Act of 2014 (PAMA) established annual targets for fee schedule expenditure reductions to be achieved via adjustments to values of misvalued codes
    - Target of 0.5% each year from 2017 through 2020
  - The Achieving a Better Life Experience Act of 2014 (ABLE) revised requirements
    - Target of 1.0% for 2016
    - Target of 0.5% for 2017 and 2018

Calculation of CY 2017 Conversion Factor

**TABLE 41: Calculation of the Proposed CY 2017 FFS Conversion Factor**

<table>
<thead>
<tr>
<th>CY 2017 KVU Budget Neutrality Adjustment</th>
<th>CY 2017 Target Reimburse Amount</th>
<th>CY 2017 Target Reimburse Amount</th>
<th>CY 2017 Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>-0.51 percent (0.9949)</td>
<td>-0.0 percent (1.0000)</td>
<td>-0.068 percent (0.9932)</td>
<td>33.0843</td>
</tr>
</tbody>
</table>

**TABLE 42: Calculation of the Proposed CY 2017 Anesthesia Conversion Factor**

<table>
<thead>
<tr>
<th>CY 2017 KVU Budget Neutrality Adjustment</th>
<th>CY 2017 Target Reimburse Amount</th>
<th>CY 2017 Target Reimburse Amount</th>
<th>CY 2017 Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>-0.51 percent (0.9949)</td>
<td>-0.0 percent (1.0000)</td>
<td>-0.068 percent (0.9932)</td>
<td>21.956</td>
</tr>
</tbody>
</table>

Shifting Risk

**Increasing Risk to Physicians and Other Providers**

<table>
<thead>
<tr>
<th>Fee for Service</th>
<th>FFS with Quality/Value</th>
<th>APMs</th>
<th>Population Health</th>
</tr>
</thead>
<tbody>
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<td></td>
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Implementation Details......

Legislation
Proposed Rule
Final Rule

ASA and the MACRA Regulatory Process

<table>
<thead>
<tr>
<th>Issued</th>
<th>Comments due</th>
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<tr>
<td>CMS Request for Information</td>
<td>Initially November 2, 2015 Extended November 17, 2015</td>
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<tr>
<td>Proposed Rule</td>
<td>April 2016</td>
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<tr>
<td>FHI Patient Codes and Categories</td>
<td>August 17, 2016</td>
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<tr>
<td>FHI Episode Groupers</td>
<td>August 25, 2016</td>
</tr>
<tr>
<td>Final Rule</td>
<td>Anticipated November 2016</td>
</tr>
</tbody>
</table>

ASA Resources:
- ASA has developed eight modules describing the Medicare Access and CHIP Reauthorization Act of 2015 and how members can learn about and prepare for its implementation in 2017.
- The Modules are designed to be viewed in consecutive order beginning with Module 1: MACRA Overview.
  - Module 1: MACRA Overview
  - Module 2: Am I a MIPS Eligible Clinician
  - Module 3: How Am I Scored in MIPS?
  - Module 4: MIPS Quality Component
  - Module 5: MIPS Resource Use Component
  - Module 6: MIPS Advancing Care Information Component
  - Module 7: MIPS Clinical Practice Improvement Activities
  - Module 8: What Should Eligible Clinicians Do To Prepare for MIPS?

The modules include information related to MACRA and the presentations discuss information from the CMS proposed rule that was released in April 2016. Specific provisions are subject to change pending the release of the final MACRA rule in late 2016.
- For questions on MACRA, please email macra@asahq.org.
Resources

- CMS Method A Episode Grouper for Medicare (EGM)
- ASA MACRA Modules
  www.asahq.org/quality-and-practice-management/macra

Thank You