American Society of Anesthesiologists®

Basics of Billing and Coding, Bundled Payments and the Value Based Modifier

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asahq.org

Disclosures

- Nothing to Disclose

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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

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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 where provided
  - Where those services/procedures were provided

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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)

- $[(RVU_{work} * GPCI_{work}) + (RVU_{pe} * GPCI_{pe}) + (RVU_{pli} * GPCI_{pli})] * CF$

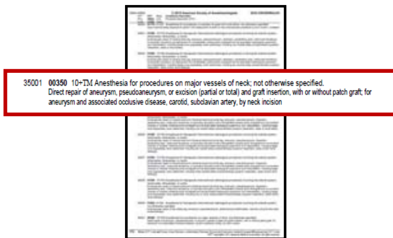
- Relative Value Units (RVU)
  - Work, Practice Expense and Professional Liability Insurance
  - RVUs are geographically adjusted per locale specific Geographic Price Cost Indices (GPCI)

- 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

2016 CROSSWALK®



Medicare Payment Formula - Anesthesia

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

Base Units	Time Units	Base+Time	CF (Unadjusted)	Allowed Amount
10	10	20	$21.99	$439.80
10	10	20	$21.25	$425.00

Arterial Line

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

Medicare Payment Formula – RBRVS

- $[(RVU_{work} * GPCI_{work}) + (RVU_{pe} * GPCI_{pe}) + (RVU_{pli} * GPCI_{pli})] * CF$
- Procedure CPT code 36620
  - (2016 RVU's and Wisconsin GPCIs)

	Work	GPCI	PE	GPCI	PLI	GPCI	Adjusted RVU	CF	Allowed Amount
Non-facility	1.15	1.000	0.22	0.955	0.10	0.566	1.45	$35.80	$51.91
Facility	1.15	1.000	0.22	0.955	0.10	0.566	1.45	$35.80	$51.91

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."*

Michael E. Porter
Keynote Speaker
Anesthesiology 2016

What is Value in Healthcare?, Michael E. Porter, Ph.D. N Engl J Med 2010; 363:2477-2481, December 23, 2010

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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

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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

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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 practitoners
    - Upward or neutral adjustment: 0% to +2X
- Maximum allowable negative adjustment if PQRS requirements not met

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2018 Value Based Payment Modifier Adjustments

Physicians, PAs, NPs CNSs and CRNAs in groups of 10 or more EPs			
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%
Physicians, PAs, NPs and CNSs CRNAs in groups of 2-9 EPs and Solo Practitioners			
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%
Groups of solely PAs, NPs and CNSs CRNAs and Solo NPPs			
Cost/Quality	**Low Quality**	**Average Quality**	**High Quality**
Low Cost	0.0%	+1.0X	+2.0X
Average Cost	0.0%	0.0%	+1.0X
High Cost	0.0%	0.0%	0.0%

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Current Methodology 3.0: Bundled Payments

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2011

2015

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Current Methodology 3.0: Bundled Payments

- Bundled Payment for Care Initiative (BPCI)

Model	Type	Services
Model 1	Retrospective	Inpatient Hospital Services
Model 2	Retrospective	I/P Hospital Services Professional Services Post-Acute Care Related Readmissions
Model 3	Retrospective	Post Acute Care Related Readmissions
Model 4	Prospective	I/P Hospital Services Professional Services Related Readmissions

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

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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., 24/7access, 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

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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
    - Proposed Rule – July 2015
    - 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

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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

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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

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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

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When?

- When does episode begin
  - Admission?
  - Defined period prior to admission?
- When does episode end?
  - Discharge from operative setting?
  - Defined interval post discharge?

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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

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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

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Bundled Payment Basics

Costs < Bundled Amount < Current FFS

Episode bundles are constructed of individual services

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Build Your Own Episodes

- Revenue vs costs
- Economics 101 and 201
- Use of your practice's data
- Tools
- Models
- PSH

Episode-Based (Bundled) Payments for Anesthesiology

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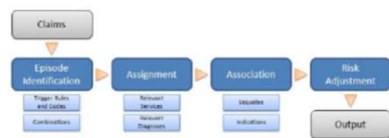
"Off the Shelf"

- CMS Method A Episode Grouper for Medicare (EGM)
  - Claims Data
  - Episode Construction

Figure 4: Episode Construction Process



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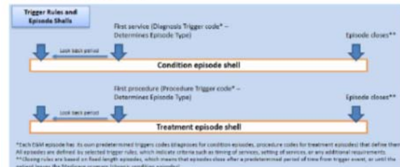
CMS Method A Episode Grouper for Medicare (EGM)

- Episode shells
  - Start date
  - End date
  - Type of episode

Figure 5: Trigger Rules and Episode Shells



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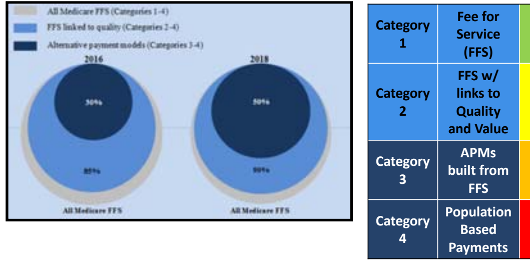
Targeted Percentage of Medicare FFS Payments Linked to Quality and Alternative Payment Models: 2016 and 2018



Category 1	Fee for Service (FFS)
Category 2	FFS w/ links to Quality and Value
Category 3	APMs built from FFS
Category 4	Population Based Payments

http://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-01-26-3.html

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Current Systems Impact on Future Systems

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

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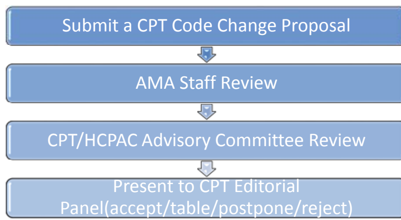
CPT Process



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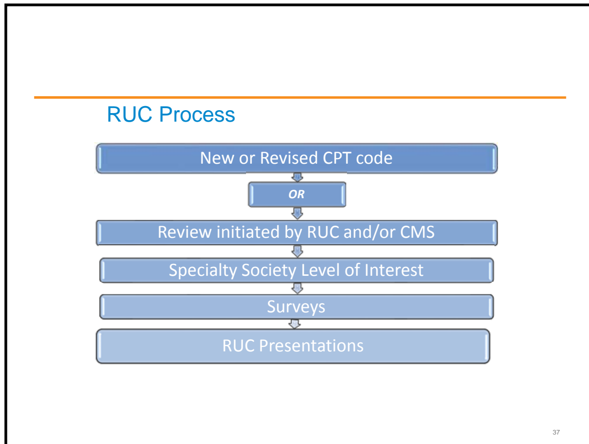
RUC Process
New or Revised CPT code
OR
Review initiated by RUC and/or CMS
Specialty Society Level of Interest
Surveys
RUC Presentations
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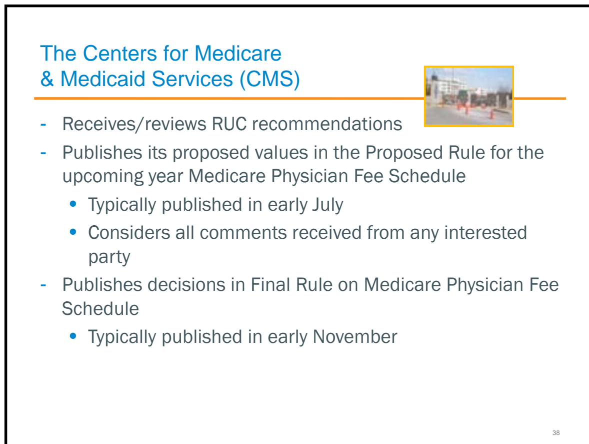
The Centers for Medicare
& Medicaid Services (CMS)
- Receives/reviews RUC recommendations
- Publishes its proposed values in the Proposed Rule for the upcoming year Medicare Physician Fee Schedule
• Typically published in early July
• Considers all comments received from any interested party
- Publishes decisions in Final Rule on Medicare Physician Fee Schedule
• Typically published in early November
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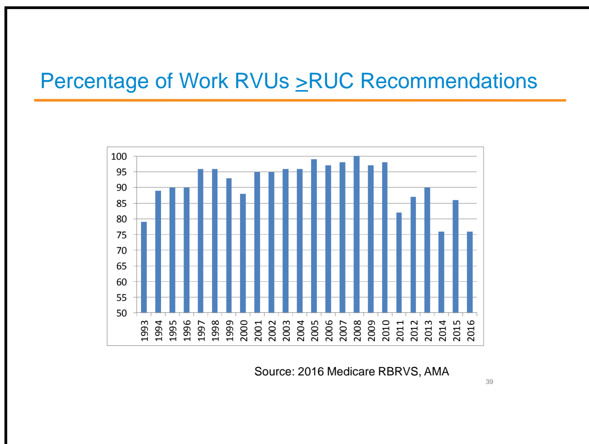
Percentage of Work RVUs >RUC Recommendations
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Source: 2016 Medicare RBRVS, AMA
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"The Department of Health and Human Services categorization of payment methods acknowledges that most value-based physician 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."

Berenson R, Goodson J, Finding Value in Unexpected Placed – Fixing the Medicare Physician Fee Schedule, NEJM, March 9, 2016, NEJM.org

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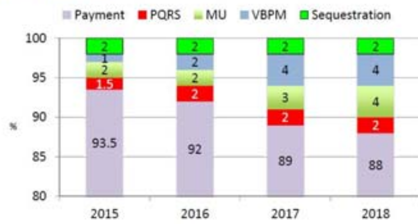
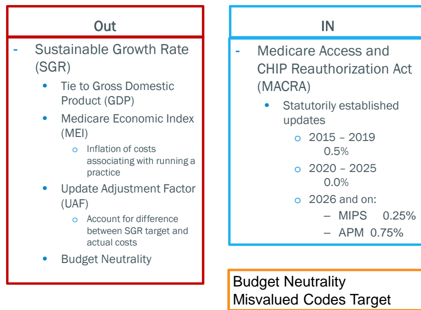
Erosion of Fee for Service



Conversion Factor



Budget Neutrality
Misvalued Codes Target

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

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Calculation of CY 2017 Conversion Factor

TABLE 41: Calculation of the Proposed CY 2017 PFS Conversion Factor

Conversion Factor in effect in CY 2016		35.8043
Update Factor	0.50 percent (1.0050)	
CY 2017 RVU Budget Neutrality Adjustment	-0.51 percent (0.9949)	
CY 2017 Target Recapture Amount	0 percent (1.0000)	
CY 2017 Imaging MPPR Adjustment	-0.07 percent (0.9993)	
CY 2017 Conversion Factor		**35.7751**

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

CY 2016 National Average Anesthesia Conversion Factor		21.9935
Update Factor	0.50 percent (1.0050)	
CY 2017 RVU Budget Neutrality Adjustment	-0.51 percent (0.9949)	
CY 2017 Target Recapture Amount	0 percent (1.0000)	
CY 2017 Imaging MPPR Adjustment	-0.07 percent (0.9993)	
CY 2017 Conversion Factor		**21.9756**

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Shifting Risk

Increasing Risk to Physicians and Other Providers			
Fee for Service	FFS with Quality/Value	APMs	Population Health

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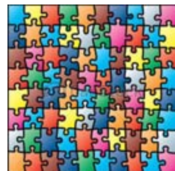
Implementation Details......

Legislation

Proposed Rule


Final Rule

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ASA and the MACRA Regulatory Process

	Issued	Comments due	
CMS Request for Information	October 1, 2015	Initially November 2,2015 Extended November 17, 2015	✓
Proposed Rule	April 2016	June 27, 2016	✓
RFI: Patient Codes and Categories		August 17, 2016	✓
RFI: Episode Groupers		August 25, 2016	✓
Final Rule	Anticipated November 2016		

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.

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Resources

- CMS Method A Episode Grouper for Medicare (EGM)
  https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/Method-A-Technical.pdf
- ASA MACRA Modules
  www.asahq.org/quality-and-practice-management/macra

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Thank You