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ICD-10 Update

- Claim must include the ICD-10 code that is supported by the documentation
  - Document diagnoses to the greatest extent known at the time of service
  - Select the diagnosis to the highest level of specificity
- Only use unspecified codes when they are the codes that most accurately reflect what is known about the patient’s condition at the time of the encounter
ICD-10 Update Cont’d

- There were over 2000 changes to ICD-10-CM codes which included new, revised, and deleted codes

- Examples of new codes
  - M25.541 Pain in joints of right hand
  - M25.542 Pain in joints of left hand
  - M25.549 Pain in joints of unspecified hand
  - R73.03 Prediabetes

  - AOA Definition
    - A fasting glucose level between 100 and 125 mg/dL
    - An A1c between 5.7 and 6.4 %
Examples of New ICD-10 Codes Cont’d

- R82.71  Bacteriuria
- Z29.11  Encounter for prophylactic immunotherapy for respiratory syncytial virus (RSV)
- Z29.12  Encounter for prophylactic antivenin
- Z29.13  Encounter for prophylactic Rho(D) immune globulin
- Z29.14  Encounter for prophylactic rabies immune globin
- Z51.6   Encounter for desensitization to allergens
- Z79.84  Long term (current) use of oral hypoglycemic drugs
2017 CPT Code Changes

- 148 New codes
- 498 Revised codes
- 81 Deleted codes
- 1 New modifier (95 Synchronous Telemedicine service rendered via a real-time interactive audio and video telecommunications system)
Examples of CPT Changes

- NCI has selected some examples of new, revised, and deleted codes for this presentation
  - Physicians should closely review all CPT changes in CPT 2017
- The examples are not in any particular order
- The chosen examples will include comments related to Medicare payment policies when appropriate as well as the 2017 Medicare Physician Fee Schedule amount
Vaccine New and Revised Codes

- Age indications have been removed from several codes (e.g., influenza vaccine) and replaced with dosage amounts

- New Vaccine Code
  - 90674  Influenza virus vaccine, quadrivalent (ccIIV4), derived from cell cultures, subunit, preservative, and antibiotic free, 0.5 mL dosage, for intramuscular use
  - Not yet on Medicare’s fee schedule. WPS is instructing physicians to hold claims until 1/1/2017.
Vaccine New and Revised Codes Cont’d

► Revised Vaccines

► 90661  Influenza virus vaccine, trivalent (ccIIIV3), derived from cell cultures, subunit, preservative and antibiotic free, 0.5 mL dosage for intramuscular use

► This revision as well as the new CPT code 90674 allows the physician to select the code for the vaccine administered, quadrivalent vs trivalent
Vaccine New and Revised Codes Cont’d

- Revised Vaccines Cont’d
  - 90734  Meningococcal conjugate vaccine, serogroups A, C, Y, and W-135, quadrivalent (MenACWY) (MCV4 or MenACWY), for intramuscular use
  
  - Revised to include the additional US vaccine abbreviation (MCV4)
  
  - MCV4 is referenced in state regulations and other resources (e.g., vaccine information statements)
Additional CPT Changes

- This list is not all-inclusive - Information selected is for this presentation
  - Laryngoscopy/Laryngoplasty
  - Bunionectomy
  - Cardiovascular
  - Spine (significant revisions for spinal instrumentation)
  - Radiology (Fluoroscopic Guidance - definitive instructions added)
Additional CPT Changes Cont’d

- Mammography
  - CAD is no longer separately reported
  - Medicare will still require the use of some “G-codes”
- Psychotherapy (8 revised codes)
- Endoscopic Laryngeal Evaluation
- PT/OT/AT Evaluations (12 new/6 revised)
  - New codes for athletic trainers - Medicare does not recognize these codes and does not cover services provided by athletic trainers)
Additional CPT Changes Cont’d

- Drug testing (3 added/5 deleted)
- Closed treatment of pelvic ring fracture and/or dislocation (1 added/1 deleted)
  - New codes specify closed treatment of posterior pelvic ring fracture(s), dislocation(s), diastasis or subluxation of the ilium, sacroiliac joint, and/or sacrum, with or without anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral; without manipulation
Pelvic Ring Fracture Cont’d

- CPT parenthetical statement:
  - To report closed treatment of only anterior pelvic ring fracture(s) and/or dislocation(s) of the pubic symphysis and/or superior/inferior rami, unilateral or bilateral, use the appropriate evaluation and management services codes
Additional CPT Changes Cont’d

- Moderate (Conscious) Sedation (6 new/6 deleted)

  - Moderate sedation symbol has been removed from 180 codes in the Surgery, Radiology, and Medicine Sections

- CPT defines moderate (conscious) sedation

  - A drug induced depression of consciousness during which patients respond purposefully to verbal commands, either alone or accompanied by light tactile stimulation. No interventions are required to maintain cardiovascular function or a patent airway, and spontaneous ventilation is adequate.
Moderate Sedation Cont’d

- Less than 10 minutes of Intraservice time for moderate sedation is not reported separately (bundled with the procedure)
- 6 existing codes were deleted (99143-99145, 99148-99150)
- 6 new codes were created
  - 99151-99153 are used when moderate sedation is provided by the same physician/QHP performing the supporting service
Moderate Sedation Cont’d

- 99155-99157 are used when moderate sedation is not provided by the physician/QHP performing the supported services.
  - These codes may be reported when the supporting service is performed in the facility setting, e.g., hospital, outpatient hospital, ambulatory surgery center (ASC), skilled nursing facility.
Moderate Sedation Cont’d

CPT clarifies that codes 99155-99157 (performed by a second physician/QHP) are not reportable when performed in the nonfacility setting.

In this scenario, e.g., performed in a physician’s office, freestanding imaging center, the second physician/QHP does not report codes 99155, 99156, 99157 because moderate sedation does not include minimal sedation (anxiolysis), deep sedation, or monitored anesthesia care (00100-01999).
Moderate Sedation Cont’d

- New initial moderate sedation codes 99151, 99152, 99155, and 99156 now require a minimum of 15 minutes
  - Reduced from the minimum of 30 minutes that was required by the deleted initial moderate sedation codes
- New add-on code time increments remain the same (15 minutes) for codes 99153 and 99157
Moderate Sedation Cont’d

▶ Be sure to review the new guidelines for appropriate use of these codes

▶ Moderate sedation requires
  
  ▶ Preservice work (history and physical, pre-assessment form including the American Society of Anesthesiologists Physical Status classification - - This time should NOT be included when selecting the appropriate code for moderate sedation.

  ▶ Intraservice work begins with administration of sedating agents, continuous attendance, monitoring patient response, ends when the procedure is completed, and the patient is stable for recovery status - used to select the appropriate code
Moderate Sedation Cont’d

**Postservice work** - do not include this time when selecting the appropriate code including, but not limited to, assessment in the post-sedation recovery period, preparation of documentation regarding sedation service and discussion with family/caregiver regarding sedation service. - This time should NOT be included when selecting the appropriate code for moderate sedation.
Medicare is Improving Payment for 2017 Primary Care Services

- Health and Behavior Assessment
- Cognitive Impairment Assessment and Care Plan Services
- Non-Face-to-Face Prolonged Evaluation and Management (E/M) Services
- Chronic Care Management
Health and Behavior Assessment

New Codes

- **96160**  Administration of patient-focused health risk assessment instrument (e.g., health hazard appraisal) with scoring and documentation, per standardized instrument

- **96161**  Administration of caregiver-focused health risk assessment instrument (e.g., depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
Health and Behavior Assessment Cont’d

- Used for the administration of the health risk assessment instrument, scoring, and documentation typically performed by nonphysician clinical staff
  - Reported “per instrument” used
  - Does not include interpretation, diagnoses, etc.
- These services provided by physicians and qualified health care professionals (QHP) is captured in the E/M code
- CPT notes these codes cannot be reported with alcohol and/or substance (other than tobacco) abuse structured screening including brief intervention described by 99408 and 99409
Health and Behavior Assessment Cont’d

- Medicare Coverage
  - 96160 and 96161 are considered active codes
    - 96160 $4.29
    - 96161 $4.29
  - Cannot be reported with
    - Annual Wellness Visit
    - Review the 2017 Correct Coding Initiative for additional bundling information
Health and Behavior Assessment Cont’d

Medicare Coverage Cont’d

Can be used for

- Assessment of maternal depression in the active care of infants
- Assessment of parental mental health as part of evaluating a child’s functioning
- Assessment of caretaker conditions as indicated where atypical parent/child interactions are observed during care
Health and Behavior Assessment Cont’d

Medicare Coverage Cont’d

Can be used for

- Assessment of caregivers as part of care management for adults whose physical or cognitive status renders them incapable of independent living and dependent on another adult caregiver

- Some examples might be intellectually disabled adults, seriously disabled military veterans and adults with significant musculoskeletal or central nervous system impairments disabled military veterans and adults with significant musculoskeletal or central nervous system impairments.
Cognitive Impairment Assessment and Care Plan Services

Beginning with dates of service 1/1/2017, CMS will provide separate payment to recognize the work of a physician/QHP in assessing and creating a care plan for beneficiaries with cognitive impairment, such as from Alzheimer’s disease or dementia, at any stage of impairment.
Cognitive Impairment Assessment and Care Plan Services Cont’d

- For 2017, CMS created a new “G-code” to describe the service - 2017 fee schedule allowance is $226.08

- G0505 Cognitive and functional assessment using standardized instruments with development of recorded care plan for the patient with cognitive impairment, history obtained from patient and/or caregiver, by the physician/QHP [e.g., NP, PA, CN; does not include psychologists/clinical social workers] in office or other outpatient setting or home or domiciliary or rest home
Cognitive Impairment Assessment and Care Plan Services Cont’d

- G0505 is considered physician work. The work relative value units assigned to the code includes:
  - 15 minutes of preservice work
  - 50 minutes of intraservice work
  - 20 minutes of postservice work

- G0505 requires the performance and documentation of 10 elements, all of which must be performed to report G0505
G0505 Required Elements

- Cognition-focused evaluation including a pertinent history and examination
- Medical decision making of moderate or high complexity (defined by the E/M guidelines)
- Functional assessment (for example, Basic and Instrumental Activities of Daily Living), including decision-making capacity
- Use of standardized instruments to stage dementia (e.g. Mini-Cog, Mini Mental Status Examination, Global Deterioration Scale, )
Medication reconciliation and review for high-risk medications, if applicable

Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized instrument(s)

Evaluation of safety (for example, home), including motor vehicle operation, if applicable

Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks
Advance care planning and addressing palliative care needs, if applicable and consistent with beneficiary preference.

Creation of a care plan, including initial plans to address any neuropsychiatric symptoms and referral to community resources as needed (for example, adult day programs, support groups); care plan shared with the patient and/or caregiver with initial education and support.
Cognitive Impairment Assessment and Care Plan Services Cont’d

- Cannot be reported on the same date of service with:
  - 99201-99215  Office/Outpatient E/M
  - 99324-99377  Domiciliary or rest home visit
  - 96103  (Psycho testing admin by computer)
  - 96120  (Neuropsych tst admin w/computer)
  - 96127  (Brief emotional/behave assmt)
  - 90785  (Psytx complex interaction)
  - 90791  (Psych diagnostic eval)
  - 90792  (Psych diagnostic eval w/med svs)
G0505 cannot be reported on the same date of service with:

- 99201-99215 Office/Outpatient E/M
- 99324-99377 Domiciliary or rest home visit
- 99341-99350 Home visits
- 99497-99498 Advance care planning codes
Cognitive Impairment Assessment and Care Plan Services Cont’d

- G0505 cannot be reported on the same date of service with (cont’d)
  - 99336-99368  (Team conf w/pat by hc provider)
  - 96103  (Psycho testing admin by computer)
  - 96120  (Neuropsych tst admin w/computer)
  - 96127  (Brief emotional/behave assmt)
  - 90785  (Psytx complex interaction)
  - 90791  (Psych diagnostic eval)
  - 90792  (Psych diagnostic eval w/med svs)
Cognitive Impairment Assessment and Care Plan Services Cont’d

- G0505 can be reported on the same date of service with
  - Chronic care management (99487, 99489, 99490)
  - Transitional care management (99495, 99496)
  - Behavioral health integration service codes (99487, 99489, 99490, 99495, 99496, G0502, G0503, G0504, G0507)
Non-Face-to-Face Prolonged E/M Services

- Beginning with dates of service on or after 1/1/2017, Medicare will begin making separate payment for non-face-to-face prolonged E/M codes.

- CPT codes
  - 99358   Prolonged evaluation and management service before and/or after direct patient care; first hour
  - 99359   each additional 30 minutes (List separately in addition to code for prolonged service)
Non-Face-to-Face Prolonged E/M Services Cont’d

- CPT 2017 includes instructions regarding the use of codes 99358-99359
- Non-face-to-face prolonged services of less than 30 minutes are not separately reported
- CMS stressed that the intent of these codes is to report extended non-face-to-face time that is spent by the billing physician or QHP (not clinical staff) that is not within the scope of practice of clinical staff, and that is not adequately identified or valued under existing codes
Non-Face-to-Face Prolonged E/M Services Cont’d

- CPT and CMS instructions are consistent in that the codes may be reported on a different date than the primary service to which it is related
  - Use of these codes MUST relate to a service or patient where (face-to-face) patient care has occurred or will occur and relate to the ongoing patient management

- CPT example
  
  An extensive record review may relate to a previous evaluation and management service performed earlier and commences upon receipt of past medical records
Non-Face-to-Face Prolonged E/M Services Cont’d

▶ CPT and CMS instructions differ on when these non-face-to-face prolonged services cannot be separately reported.

▶ CMS does not believe there is significant overlap with the following codes to be reported in addition to
  ◀ Chronic Care Management (CCM) codes 99487, 99489, 99490
  ◀ Behavioral Health Integration (BHI) codes G0502, G0503, G0504, G0507
Non-Face-to-Face Prolonged E/M Services Cont’d

In the final rule, CMS stated that the physician/QHP’s work in the provision of CCM and BHI services is related to the direction of ongoing care management and coordination activities of other individuals, compared to the work of 99358 and 99359, which is described as personally performed and directly related to a face-to-face service.

Fee Schedule Allowance

- 99358  $108.09
- 99359  $ 52.00
Chronic Care Management

- Medicare began covering Chronic Care Management (CCM) services reported with 99490 on 1/1/2016

- 99490 Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
  - chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
  - comprehensive care plan established, implemented, revised, or monitored
Chronic Care Management Cont’d

- Effective with dates of service on or after 1/1/2017, when appropriate, Medicare will allow physicians/QHPs to report the CPT codes for Complex Chronic Care Management (CCMC)
Complex Chronic Care Management Cont’d

99487 Complex chronic care management services, with the following required elements:

- multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- establishment or substantial revision of a comprehensive care plan
- moderate or high complexity medical decision making
- 60 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

99489 each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure)
Chronic Care Management

- Beginning 1/1/2017, CMS believes it has simplified the rules regarding initiating visit, electronic records, and patient consent

- 2017 Chronic Care Management Service Elements And Billing Requirements
  - Initiating Visit
    - Initiation during an AWV, IPPE, or face-to-face E/M visit (Level 4 or 5 visit not required), for new patients or patients not seen within 1 year prior to the commencement of chronic care management (CCM) services
Structured Recording of Patient Information Using Certified Electronic Health Record (EHR) Technology

- Structured recording of demographics, problems, medications and medication allergies using certified EHR technology. A full list of problems, medications and medication allergies in the EHR must inform the care plan, care coordination and ongoing clinical care.
2017 Chronic Care Management Service Elements and Billing Requirements Cont’d

► 24/7 Access & Continuity of Care:
  ► Provide 24/7 access to physicians or other qualified health care professionals or clinical staff including providing patients/caregivers with a means to make contact with health care professionals in the practice to address urgent needs regardless of the time of day or day of week
  ► Continuity of care with a designated member of the care team with whom the beneficiary is able to schedule successive routine appointments
Comprehensive Care Management

Care management for chronic conditions including:

- Systematic assessment of the beneficiary’s medical, functional, and psychosocial needs
- System-based approaches to ensure timely receipt of all recommended preventive care services
- Medication reconciliation with review of adherence and potential interactions
- Oversight of beneficiary self-management of medications
Comprehensive Care Plan:

Creation, revision and/or monitoring (as per code descriptors) of an electronic patient-centered care plan based on a physical, mental, cognitive, psychosocial, functional and environmental (re)assessment and an inventory of resources and supports; a comprehensive care plan for all health issues.

- Must at least electronically capture care plan information, and make this information available timely within and outside the billing practice as appropriate. Share care plan information electronically (can include fax) and timely within and outside the billing practice to individuals involved in the beneficiary’s care.

- A copy of the plan of care must be given to the patient and/or caregiver.
Management of Care Transitions:

- Management of care transitions between and among health care providers and settings, including referrals to other clinicians; follow-up after an emergency department visit; and follow-up after discharges from hospitals, skilled nursing facilities or other health care facilities.

- Create and exchange/transmit continuity of care document(s) timely with other practitioners and providers.
Home- and Community-Based Care Coordination:

- Coordination with home and community based clinical service providers
- Communication to and from home- and community-based providers regarding the patient’s psychosocial needs and functional deficit must be documented in the patient’s medical record
Enhanced Communication Opportunities

Enhanced opportunities for the beneficiary and any caregiver to communicate with the practitioner regarding the beneficiary’s care through not only telephone access, but also through the use of secure messaging, Internet, or other asynchronous non-face-to-face consultation methods.
Beneficiary Consent:

- Inform the beneficiary of the availability of CCM services; that only one practitioner can furnish and be paid for these services during a calendar month; and of their right to stop the CCM services at any time (effective at the end of the calendar month)

- Document in the beneficiary’s medical record that the required information was explained and whether the beneficiary accepted or declined the services
Medical Decision-Making

**Complex CCM** services require and include medical decision-making of moderate to high complexity (by the physician or other billing practitioner)
2017 Fee Schedule

- Chronic care management (does not include any E/M service)
  - 99490 $40.44
  - 99487 $88.14
  - 99489 $44.23

- Transitional care management (includes 1 E/M service)
  - 99495 $156.30
  - 99496 $221.15
Medicare Physician Payments

- Conversion Factor Changes
  - 2016 $35.8043
  - 2017 $35.8887 (8.44¢)
Medicare Payment Reform

- Medicare Access & CHIP Reauthorization Act of 2015 (MACRA)
  - Repealed the flawed Medicare sustainable growth rate (SGR) formula that calculated payment cuts for physicians.
  - Creates a new framework for rewarding physicians for providing higher quality care by establishing two tracks for payment. Typically referred to as the “Quality Payment Program” (QPP):
    - Merit-based Incentive Payment System (MIPS), and
    - Alternative Payment Models (APMs)
  - Consolidates three existing quality reporting programs (Physician Quality Reporting System, Value-based Payment Modifier, and meaningful use), plus adds a new performance category, into a single system through MIPS
Providers Affected by MIPS

- Medicare Part B clinicians billing more than $30,000 a year and providing care for more than 100 Medicare patients a year.
  - These clinicians include:
    - Physicians
    - Physician Assistants
    - Nurse Practitioners
    - Clinical Nurse Specialists
    - Certified Registered Nurse Anesthetists
Providers Not Affected by MIPS

- Newly-enrolled Medicare clinicians
  - Clinicians who enroll in Medicare for the first time during a performance period are exempt from reporting on measures and activities for MIPS until the following performance year
- Clinicians below the low-volume threshold - Medicare Part B allowed charges less than or equal to $30,000 OR 100 or fewer Medicare Part B patients
- Clinicians significantly participating in Advanced APMs
Advanced Alternative Payment Models (APMs)

- An APM is a payment approach, developed in partnership with the clinician community, that provides added incentives to clinicians to provide high-quality and cost-efficient care. APMs can apply to a specific clinical condition, a care episode, or a population.

- APMs may offer significant opportunities to eligible clinicians who are not immediately able or prepared to take on the additional risk and requirements of Advanced APMs.
Advanced Alternative Payment Models (Advanced APMs) enable clinicians and practices to earn greater rewards for taking on some risk related to their patients’ outcomes.

It is important to understand that the Quality Payment Program does not change the design of any particular APM. Instead, it creates extra incentives for a sufficient degree of participation in Advanced APMs.
APMs Cont’d

In 2017, CMS anticipates that the following list will be Advanced APMs:

- Comprehensive ESRD Care (CEC) - Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Next Generation ACO Model
- Shared Savings Program - Track 2
- Shared Savings Program - Track 3
- Oncology Care Model (OCM) - Two-Sided Risk
APMs Cont’d

- Where Innovation is Happening
  - See where our Innovation Model Partners are located on the CMS website at [https://innovation.cms.gov/](https://innovation.cms.gov/)

- Once you're in an Advanced APM, you'll earn the 5% incentive payment in 2019 for Advanced APM participation in 2017 if:
  - You receive 25% of your Medicare Part B payments through an Advanced APM or
  - See 20% of your Medicare patients through an Advanced APM
You'll need to send in the quality data required by your Advanced APM. Your model's website will tell you how to send in your Advanced APM's quality data.

If you leave the Advanced APM during 2017, you should make sure you've seen enough patients or received enough payments through an Advanced APM to qualify for the 5% bonus. If you haven't met these thresholds, you may need to submit MIPS data to avoid a downward payment adjustment.
MIPS

The four categories establish a composite performance score (0-100) that will be compared against a threshold and then used to determine physician payment adjustments. The categories that make up the MIPS score are:

- **Quality** - Based on PQRS - For 2019 (based on 2017 data), this category will account for 50% of the total score
- **Resource use** - For 2019, cost accounts for 0% of your score in 2017. In the future, this category will account for 10% of the total score
- **Advancing Care Information (ACI)** - Based on MU (must use certified EHR technology) - For 2019, it appears that reporting quality measures is sufficient. Eventually, this category will account for 25% of the total score
- **Clinical practice improvement activities** - New performance category - For 2019 (based on 2017 data), ??? Eventually, this category will account for 15% of the total score
MIPS Payment Adjustment

- MIPS payment adjustments will begin January 1, 2019 (based on 2017 data)
- The maximum payment negative adjustment amount starts at 4 percent in 2019 and incrementally increases to 9 percent in 2022 and onward.
- For 2019 to 2024, there will also be positive payment adjustment given to the highest MIPS performers for exceptional performance.
MIPS Payment Adjustment Cont’d

- Not participating in the Quality Payment Program
  - If you don’t send in any 2017 data, then you receive a negative 4% payment adjustment

- Test
  - If you submit a minimum amount of 2017 data to Medicare (for example, one quality measure or one improvement activity), you can avoid a downward payment adjustment
Partial

- If you submit 90 days of 2017 data to Medicare, you may earn a neutral or small positive payment adjustment
  - Report 6 quality measures, including an outcome measure, for a minimum of 90 days
  - Report each measure on at least 50 percent of the applicable patients.
  - Claims submission only requires you to report on Medicare, Railroad Medicare and Medicare as a secondary payer. If reporting via EHR or registry, you must report on all payers.

Full

- If you submit a full year of 2017 data to Medicare, you may earn a moderate positive payment adjustment
MIPS Cont’d

- The CMS Quality Payment Program Overview Fact Sheet has more information regarding the MIPS requirements. It is available on the CMS website at https://qpp.cms.gov/docs/Quality_Payment_Program_Overview_Fact_Sheet.pdf
Thanks for inviting me to your meeting. I hope to see you again next year!

Happy Holidays