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Doctors Left In Dark By CMS Over MACRA Compliance Requirements

Doctors are potentially facing a loss of millions in Medicare reimbursement dollars due to lack of MACRA-related guidance from CMS, according to a letter to CMS from the Medical Group Management Association.

In the final rule, announced in December, CMS said it would exempt physician practices with less than $30,000 in Medicare charges or fewer than 100 unique Medicare patients per year from complying with the Merit-based Incentive Payment System outlined under MACRA. The threshold in the final ruling would exclude 30% of physicians from complying from MIPS, according to an American Medical Association analysis. The agency was supposed to formally notify these physicians in December of their exemptions. However over three months into the first year of MACRA implementation, doctors have not received the notifications. "This is generating considerable frustration and confusion," the MGMA said in a mid-March letter to CMS leadership. A CMS spokesperson said the agency plans to send out the notifications this spring, and did not comment on why the agency missed the December deadline. The MGMA said this answer is unacceptable as the doctors need answers now. "Physicians need certainty to make timely business decisions about investments in technology, clinical systems and the staff necessary to comply," said Anders Gilberg, senior vice president of government affairs at MGMA.

Medicare reimbursement for providers in 2019 will be based on how well doctors perform on their metrics this year. Under MIPS, physicians can earn plus or minus 4% of reimbursement in 2019.

CMS Finalizes It's Fiercely Opposed Uncompensated-Care Rule

CMS has finalized a controversial ruling that changes how Medicaid pays hospitals that serve high levels of Medicaid and uninsured patients. With the new ruling, CMS will define the cost of uncompensated care by subtracting any payments made by Medicare or private insurance. In the past, hospitals were given the difference between the total cost of inpatient and outpatient care for Medicaid patients and the total Medicaid payments received. These included fee-for-service, managed-care and Medicaid payments. The draft rule was originally criticized by hospitals and state Medicaid agencies because the ruling could dissuade hospitals from wanting to treat low income individuals. The changes go into effect in 60 days from April 3, and hospitals wanted a grace period to comply with the rule. Tom Nickels, executive vice president of the American Hospital Association said in a statement that hospitals need more time to make adjustments to ensure compliance. The Government Accountability Office estimates that 7.6 million out of the 56 million people enrolled in the Medicaid program in 2012 had private coverage and 10.6 million Medicaid enrollees had other public coverage, including Tricare and Medicare.

> "The CMS will now define the cost of uncompensated care by subtracting any payments made by Medicare or private insurance."

Uncompensated-care funds were on the chopping block in the Affordable Care Act, which presumed that Medicaid expansion would cover uninsured low-income patients. The fund is significant—in 2015 it totaled $11.9 billion.

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Billing For Cosmetic Procedures During A Scheduled Surgery

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Many patients ask if a cosmetic procedure can be done in conjunction with their scheduled surgery. What is very important to remember is to carve out the time spent on the medically necessary portion of the case so that any third-party payer is not mistakenly tricked into paying for the extra time spent on the unauthorized (often non-covered) cosmetic portion of the case. This excludes reconstructive surgery and related services, as they are procedures that are performed on structures of the body to improve or restore bodily function or to correct a deformity resulting from disease, trauma, congenital or developmental anomalies, or previous medical treatments. Reconstructive services also include procedures which treat significant medical symptoms such as pain, bleeding, or chronic infections.

Cosmetic surgery and related services are procedures that are performed to reshape structures of the body in order to alter or improve an individual's appearance, self-perception, or alter the manifestations of the aging process. Cosmetic surgical procedures do not restore bodily functions or correct deformities resulting from trauma, congenital or developmental anomalies or previous medical treatments.

Cosmetic surgery does not become reconstructive surgery because of psychological or psychiatric reasons either. Now that we have defined the parameters, how do we ensure clarity in our billing? No matter the method of documentation, time spent on the cosmetic portion of the case is carved out with its own start and stop times from the portion of the case that is covered by a third-party payer. Some suggestions include, but are not limited to, generating two anesthesia records. There will most likely be two operative reports. If a singular record is used, make sure the start and stop of each case are clearly documented in the medical record and are NOT overlapping.

Collect all cosmetic payments prior to the procedure further ensuring no chance of confusion for the third-party payer or the patient. In the new world of high deductible co-pays it's important to ensure that the patient is clear that the prepayment rate for the cosmetic portion does not go toward their annual deductible agreement with their insurance since it is not a medically covered or billed procedure. Make sure to have the patients sign an agreement for the cosmetic portion clearly defining how the fees will be allocated.

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Kimberly Flayhart is a Client Service Manager with Perioperative Services, LLC. Her background includes over 25 years of coding, compliance, practice management and business intelligence experience. Before joining Periop, her past positions included 22 years as a Associate Administrator for University of Maryland Anesthesiology Associates, P.A.