MBU TIMES

VOLUME 10
ISSUE 06
June 2016

MONTHLY NEWSLETTER OF MEDICAL BILLING UNLIMTED, INC.

Quality Reporting

For 2016 PQRS submissions, it is recommended that providers focus on finding cross-cutting measures based on their high-volume activities for which they have a tendency to perform well on. A cross-cutting measure is any measure that is broadly applicable across multiple settings and eligible professionals or group practices within a variety of specialties. The reporting requirement of a cross-cutting measure is triggered if an eligible professional or group practice bills for a face-to-face encounter. The requirement for reporting cross-cutting measures is new to the PQRS program and began in 2015.

There are 23 cross-cutting measures to choose from for 2016. All practices are required to report at least one cross-cutting measure this year. Providers will need to meet the minimum threshold of 15 Medicare patients for a given cross-cutting measure to be eligible for reporting. Providers achieve successful reporting if measures are reported on 50% or more of those eligible patients. Failure to report one, even if successfully reporting all other PQRS measures, is considered to not have successfully satisfied the reporting requirements. During an April 21st National Provider Call, a CMS spokesperson warned that failure to report one measure is cause to receive a payment penalty. For more information on the 2016 cross-cutting measures, go to https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/PQRS/Downloads/2016_PQRS-Crosscutting.pdf.

Medicare proposes sweeping changes to physician payments

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule outlining how the agency envisions implementing the Medicare physician payment reforms enacted as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). With the passage of MACRA, Congress set Medicare on a path toward a system that focuses more on clinical quality and cost effectiveness. This in turn will move Medicare away from automatic, annual updates hindered by the threat of payment cuts under the flawed sustainable growth rate formula. The proposed rule will establish a new approach to streamline and simplify the PQRS, Meaningful Use, and Value-Based Payment Modifier programs into a single Merit-Based Incentive Payment System (MIPS). It also proposes to remove the "all-or-nothing" scoring approach and add much-needed flexibility to the quality reporting. MACRA would set 2017 as the first performance measurement year for the new MIPS. It will additionally provide detail criteria for qualification as an alternative payment model participant (APM), including eligibility for future incentive payments. The CMS website, www.cms.gov, has a series of on-demand webinars that outline how CMS envisions implementing physician payment reforms enacted as part MACRA.

Questions? Please call Angie at 915-774-5506

1. MGMA, Week of April 27, 2016, *MGMA Washington Connection*
2. Part B News by Decision Health, May 2, 2016, Vol. 30, Issue 18
3. MGMA, Week of May 4, 2016, *MGMA Washington Connection*
4. CMS.gov