ABC’S FOR NEW PRACTICE MANAGERS
Overview

- RVU & WRVU Basics
- Payer Methodologies and Contracting Strategies
- Practice Fee Schedules
- Benchmarking/Dashboard Basics
- Budgeting for the Medical Practice
- Elements of Physician Compensation
- Regulatory & Compliance Overview
RVU BASICS
RBRVS

- Resource Based Relative Value Unit

- Basis of the Physician Fee Schedule (PFS) which applies to the professional services of eligible providers

- Conversion Factor Application
  - SGR – Repealed on April 1, 2015, now increase of .05% for 5 years
  - GPCI
  - Payment reductions – sequester, PQRS, VBPM
RVU Components

- WRVU – Work RVU
- PE RVU – Practice Expense RVU
- MRVU – Malpractice RVU
CMS Payment Methodologies

- PFS Payment = [(RVU work × GPCI work) + (RVU PE × GPCI PE) + (RVU MP × GPCI MP)] × CF.

- Other CMS Payment Methodologies
  - Medications – Average Sales Price
  - Laboratory
  - Ambulatory Surgery Fee Schedule
  - Hospital Outpatient Department
  - DME Schedule
RVU Basics

- Origination – Harvard School of Business in 1985; signed into law in 1989
- RBRVS payment system implemented in January 1992
- AMA (RUC) RVS Update Committee provided initial RBRVS recommendations
RVU Basics

- RVU tables are continually updated for misvalued codes, new CPT codes, etc.
- Every 5 years, the RVU table is comprehensively updated.
- All changes to the RVU tables must not exceed $20M/yr.; changes beyond that magnitude result in:
  - Transitional periods
  - Reassigned RVU amounts
Work Relative Value Unit (WRVU)

- **Physician Work Effort**
  - Time to perform the service
  - Technical skill and physical effort
  - Mental effort and judgment
  - Stress due to potential risk to the patient

- **2007 Transition** – AMA successfully initiated significant increase in E/M services resulting in $30M increase
  - Budget Neutrality Adjuster
  - 4 year transition
Work Relative Value Unit

- Until 2007 Consistent
- Widely used to track Productivity
- Common Metric to track Payer Mix shifts

- Often used in Compensation Plans
  - Employed Practitioner Plans
  - Uses in Independent Practitioner plans
  - Provides Revenue Neutral Methodology for risk sharing
Practice Expense RVU

- Site of Service 2002
  - Facility Components
    - Appointment scheduling, billing and collection costs
  - Non-facility
    - Clinical and non-clinical labor, medical supplies & equipment, billing & reception costs, legal and accounting, rent, utilities, etc.
  - Resulted in significant decreases to Gastroenterology, Urology, Emergency Medicine
Practice Expense RVU

- Several changes in methodology
  - Full resource allocation in 2002

- PE/HR – AMA Practice Expense per hour
  - AMA Socioeconomic Monitoring
  - Clinical Practice Expert Panel
  - Phase in from 2007 – 2010
  - Resulted in multiple changes to many surgical specialties
Recent PE RVU Changes

- AMA Physician Practice Information Survey (PPIS) began in 2007;
  - 3656 respondents, 51 specialties now primary source to update PE/HR
  - Initiated in 2010 and phased in through 2013
  - Encompassed utilization rates for equipment, phased in over 3 years from 50% - 90%.
  - Significantly impacted services such as echocardiograms, etc.
  - Resulted in significant changes to Cardiology, Radiation Oncology, etc. Sleep Medicine RVU’s to begin PPIS input in 2015
Malpractice RVU

- Accounts for approximately 4% of the RVU total weight
- Changed to resourced based in 2002
- Last comprehensive change in 2004
- Next major review of Malpractice RVU will be 2015
RVU Table Adoption by Payers

- CMS publishes new table in November of each year for subsequent year adoption.
- WA Medicaid and L&I adopts in July of the following year
- Commercial payers can adopt as early as one year out.
RVU Annual Recommendations

- High Volume Code Review
  - Transitional vs. Fully implemented
  - Pro-active Contract Negotiations
  - Budget Adjustments

- Fee Schedule Update
Important Links

2015 Final Rule

- http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1612-FC.html
Important Links

- Physician Fee Schedule Look Up
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PFSlookup/index.html

- RVU Tables
  - http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html
Important Links

- Medicare Laboratory Fee Schedule
  - [http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html](http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/clinlab.html)

- Physician Average Sales Price
Important Links

- Ambulatory Surgery Fee Schedule
PAYER METHODOLOGIES & CONTRACT NEGOTIATION STRATEGIES
Payer Methodologies

- Specified Year CMS RVU Table & Conversion Factor
- % of a Specified Medicare Year
- Clarifying Language
  - Site of Service
  - GPCI Application
  - Transitional or Fully Implemented
Payer Methodologies

- Payment Modifiers
  - 53 Discontinued Services = 50%
  - 54 Pre-Op Only – CPT specific payment files
  - 55 Post-Op Only – CPT specific payment files
  - 62 Co-surgeons 62.5%
  - 66 Team Surgeons 33%
Payer Methodologies

- Payment Modifiers
  - 80, 81, 82 Asst. at Surgery = 16%
  - AS Asst. at Surgery PA = 14%
  - 50 Bilateral Surgery = 150%
  - 51 Multiple Procedures = 50%
  - 52 Reduced Services = 50%
Multiple Procedure Reduction

- Highest RVU Value 100%; second code same session 50%, third – fifth code 25%
- Highest RVU Value 100%; second – fifth codes 50%
- Highest RVU value 100%; second code 50%; third code 25%
Endoscopy Code Family Reduction

Endoscopy Code Family Example

**Step 1: Primary Code**
CPT code 45380: full fee schedule amount ($248.50)

**Step 2: Same Code Family Reduction**
Base procedure: CPT code 45378 (fee schedule amount = $206.84)
CPT code 45381: fee schedule amount minus base scope ($235.81 - $206.84) = $28.97

**Step 3: Total Allowable for Multiple Proc. Same Family**
Add adjusted amounts for CPT codes 45380 and 45381:
$248.50 + $28.97 = $277.47
Payer Methodologies

- Ancillary Services
  - % of Medicare Laboratory Fee Schedule
  - % of Average Sales Price
  - Immunization reimbursement

- Radiology Applications
  - Additional Discounts
  - Separate conversion factors
Internal Contract Benchmarking

- RVU Year Evaluation

- Pull top volume codes for last 12 months (codes performed more than 30 times per year)

- Pull last 5 years or contract designated years
## Internal Benchmarking RVU Tables

<table>
<thead>
<tr>
<th>CPT</th>
<th>Volumes</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
<th>2012</th>
<th>2013</th>
</tr>
</thead>
<tbody>
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<td>99211</td>
<td>157</td>
<td>0.50</td>
<td>0.53</td>
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<td>3.68</td>
<td>4.05</td>
<td>4.11</td>
<td>4.20</td>
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</table>
Weighted RVU Profile

- Multiply the volumes by the RVU for each CPT code and for each of the 5 RVU tables
- Sum the total and compare the most favorable RVU years
# RVU Evaluation Weighted Evaluation Profile

<table>
<thead>
<tr>
<th>CPT</th>
<th>Volumes</th>
<th>2009</th>
<th>2010</th>
<th>2011</th>
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<td>736.00</td>
<td>810.00</td>
<td>822.00</td>
<td>840.00</td>
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<td><strong>Total</strong></td>
<td></td>
<td><strong>8,186.19</strong></td>
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<td><strong>9,607.23</strong></td>
<td><strong>9,776.08</strong></td>
<td><strong>10,052.08</strong></td>
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</table>
Weighted Payer Profiles

- Multiply individual Payer Conversion Factors by the Designated RVU for each CPT code and Multiply that by volumes
  \[ CF \times (volumes \times RVU \text{ Value}) \]

- Multiply Medicare Allowables by Volumes

- Sum the Totals for each Payer and Compare to Medicare
# Internal Benchmarks

<table>
<thead>
<tr>
<th>CPT</th>
<th>Volumes</th>
<th>Payer A</th>
<th>Payer B</th>
<th>Payer C</th>
<th>Medicare</th>
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</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>2009</td>
<td>2010</td>
<td>2013</td>
<td>Current Year</td>
</tr>
<tr>
<td>RVU Year</td>
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<tr>
<td>CF</td>
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<td></td>
<td></td>
<td>2014</td>
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<td><strong>$ 485,919</strong></td>
<td><strong>$ 522,708</strong></td>
<td><strong>$ 344,357.0</strong></td>
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<tr>
<td><strong>% of Medicare</strong></td>
<td></td>
<td>128%</td>
<td>141%</td>
<td>152%</td>
<td>100%</td>
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<td><strong>Ranking</strong></td>
<td></td>
<td>3</td>
<td>2</td>
<td>1</td>
<td></td>
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Contract Negotiations

RVU Related

- Market Parity – Internal Benchmarking

- Disproportionate Decrease
  - RVU Values
  - Payment Policies on Local Coverage Determinations

- Market Adequacy and Peer Comparison
Contract Negotiations

- Value Based Contracting
  - Patient Engagement Tools
  - PMPM for Care Coordination
  - % of Increase for Cost Savings or QM
  - ACO Risk Sharing Pools and Exclusivity
Contract Terms

- Quality Reporting
  - Beyond applicable reporting

- Application of Other Manuals and Policies
  - Exclusion Testing
  - Payment Policies
Contract Terms

- Merger Language
  - Termination and applicability

- Term and Termination
  - Termination without cause tied to “initial term”
  - Active vs. Passive renewal
  - Multiple year contract and inflationary increases
Contract Terms

- No Charge Master Increases
  - During contract term

- Payer Fee Schedule Changes
  - Unilateral non-signatory changes
  - Reduction for mid-level
  - Multiple procedure policies
  - LCD Policies
SESSION BREAK
PRACTICE FEE SCHEDULES OR CHARGE MASTERS
Payer Contract Provisions

- Lessor of Language
- Dual Fee Schedules for Medicare and Commercial Payers
- Private Pay Discounts
- Change in Fee Schedule Provisions
  - Acquisition
  - General Updates
Fee Schedules/Charge Master

- Market Value Approach
  - Purchased for Geographic Area
  - Provides Fee Schedule by Percentile
  - Not related to internal benchmarks
Fee Schedules/Charge Master

- Internal Benchmarking
  - Compares Charge Master to Allowables in Market Place

See Table
# Internal Benchmarking

<table>
<thead>
<tr>
<th>CPT</th>
<th>Payer A</th>
<th>Payer B</th>
<th>Payer C</th>
<th>Medicare</th>
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<tr>
<td>RVU Year</td>
<td>$54</td>
<td>$56</td>
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<tr>
<td>CF</td>
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<td>99215</td>
<td>$188</td>
<td>$206</td>
<td>$211</td>
<td>$144</td>
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Internal Benchmarking

- RVU Year Evaluation
- Conversion Factor Evaluation
- Determine Internal Conversion Factor and multiply by RVU
- MAX Formula to create internal RVU table to control year to year variability
Fee Schedules/Charge Master

- Create Cost Based Benchmarks
- Current Expenses
- Physician Salaries at National Benchmarks for Productivity & Benefits
- Compare Cost per RVU to Collections per RVU
- Account for non-negotiable contracts, determine contract needs to break even
- Determine internal CF to allow for range of collections
BENCHMARKING BASICS
Benchmarking Purpose

- Compare, understand & Interpret data points into operationally actionable items
- Keep it concise, yet relevant
- Never look at just one benchmark
- Use the benchmarks to engage - Physicians – Operations & Finance – Clinic Managers and Better Practice Performance
Internal or External Benchmarks

- **Internal Benchmarks**
  - Measures success or progress within the organization
  - Monthly results measured against internal baseline data
Internal or External Benchmarks

- External Benchmarks
  - Local, Regional or Nationally Published Benchmarks such as MGMA
  - Compares your practice or practitioners to other physicians outside of the organization
Survey Data

- MGMA Compensation Survey & Cost Survey
  - Data points are each individual questions and are not directly correlated to each other
  - Significant number of data points available for multiple specialties
Survey Data

- MGMA Best Practices Gold Book
  - Data points within each benchmark profile are correlated to best and less effective financial outcomes
  - Limited number of specialties and fewer data points
Creating a Benchmark Profile

- Determine Key Indicators
- Determine relevant specialty benchmarks
- Pull MGMA or other Benchmark Data 25\textsuperscript{th}, Median and 75\textsuperscript{th} Percentile data points as appropriate for Profile
- Pull Internal Data and aggregate according to “by Physician FTE” or by “Provider FTE” comparison
Benchmark Profiles

- Practice Relevancy to MGMA Data
  - Collections per Physician
  - WRVU per Physician
  - Collections per WRVU
  - Charges per Physician
  - Medicare and Medicaid % per practice
Benchmark Profiles

- Revenue Cycle & Productivity
  - Charges, Collections & Adjustments
  - Collections per WRVU
  - WRVU per Physician
  - Days in AR
  - Aged AR over 120 days
  - Top 5 Non-contractual Write offs
  - Top 5 Denial Reasons
  - Self Pay collection %
  - Net Collection %
Benchmark Profiles

- Revenue Cycle
  - Charges, Collections & Adjustments
    - Can be ideal for independent practices that do not use WRVU
    - Can indicate changes in payer mix, volume & anticipated income for both independent and employed practices or poor revenue cycle performance
Benchmark Profiles

- **Revenue Cycle**
  - Collections per WRVU
    - Isolates changes in payer mix or case mix
  - WRVU per Physician
    - Isolates changes in volume
Benchmark Profiles

- **Revenue Cycle**
  - **Days in AR**
    - Overall Revenue Cycle Performance indicator; actual issues could be clinical, coding or billing related – all are part of Revenue Cycle
  - **Aged AR over 120 days**
    - Determines most vulnerable Income – over 90 days is typically valued at 50% of anticipated income; over 120 at zero for budget “reserves”
Benchmark Profiles

Revenue Cycle
- Top 5 Non-contractual Write offs
  - Isolates reasons for claims that result in preventable write offs & actionable operational or policy changes
    - No referral
    - No Preauthorization
    - Not Medically necessary & no ABN
    - Bundled Service
    - Untimely Filing
Benchmark Profiles

- Revenue Cycle
  - Top 5 Denial Reasons
    - Isolates problems causing delays in billing & actionable operational or policy changes
      - Clinical issues
      - Coding issues
      - Billing issues
Benchmark Profiles

Revenue Cycle

- Self Pay collection %
  - Pulse check to see if Self Pay Collection policies need improvement
    - Copayment Collections
    - Pre-Collections Policies
    - Collection Policies

- Net Collection %
  - Determines if Non-contractual Write offs are within industry standards for specialty & ownership
Benchmark Profiles

 Case Mix – Internal Benchmarks
  • New and Established Patients
    ○ Identifies panel limitations for primary care
    ○ Identifies total volumes
    ○ Identifies potential consultation decline for specialists
Benchmark Profiles

- Case Mix – Internal Benchmarks
  - **Volume by Service Type**
    - Identify critical services
      - New & Established Patients
      - Well Visits
      - Outpatient Procedures (specificity)
      - Inpatient Procedures
      - Infusion & new Infusion
      - Other
Benchmark Profiles

- Case Mix – Internal Benchmarks
  - **WRVU per Visit for E/M**
    - For specialties with high volumes of E/M services even reasonable coders lose significant amounts to under coding for services

<table>
<thead>
<tr>
<th>Visits Daily</th>
<th>3</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difference in one level of service</td>
<td>$30</td>
</tr>
<tr>
<td>Days per Week</td>
<td>4</td>
</tr>
<tr>
<td>Weeks per year</td>
<td>46</td>
</tr>
<tr>
<td>Annual Collections Reduction</td>
<td>$16,560</td>
</tr>
</tbody>
</table>
Benchmark Profiles

- Case Mix – Internal Benchmarks
  - **WRVU per outpatient or inpatient procedure** (if available)
    - Case mix for surgery can change with CPT Updates or changes in case types or complexity resulting in significant reductions in collections
    - Classify major case types and monitor monthly if software has ability to pull this metric
    - Review Dashboard Example
BUDGETING FOR MEDICAL PRACTICES
Inclusive Project

- **Engagement**
  - Practice Administrator/Manager
    - Should lead budget process
  - Practitioners
    - Understand the most about continued volumes, changes in practice, future opportunities for procedures, etc.
Inclusive Project

- **Coders**
  - Responsible for code changes, new bundled items, changes in payable services

- **Billers**
  - Coverage determinations which will result in fewer or alternative services
Revenue

- Determine Total Volumes
  - E/M Services
  - Inpatient Procedures
  - Outpatient Procedures
  - Collection Amount
  - WRVU Amount

- As a reality check, divide budgeted WRVU by Budgeted collections to see if within realistic parameters
Revenue

- Review Growth Trend
  - Last 12 months
  - Last 6 months

- Justify with Budget Projections
Expenses

- Using volumes, determine anticipated costs for:
  - Staffing & Benefits
  - Office & Medical Supplies
  - Rent
  - Physician Compensation & Benefits
  - Other General Overhead
  - A/R reserves
  - Use categories for which there are external benchmarks
Benchmark Success

- Benchmark Budget vs. Actual
  - Collections per WRVU
  - Total WRVU
  - Support Staff Salary & Benefits
  - Office & Medical Supplies
  - Rent
  - Physician Compensation & Benefits
  - Other General Overhead
Benchmark Success

- Understand how your budget and your actual performance measure up to External Benchmarks
  - Perform external benchmark profile for budget
  - Perform external benchmark profile for actual performance that year
ELEMENTS OF PHYSICIAN COMPENSATION
Conceptual Agreement

- Compensation plans should be a balance of the following initiatives
  - Operational Goals – what performance or quality measures do you want to reward
  - Strategic Goals – emerging service lines, cross coverage, physician retention, etc.
  - Financial Goals – alignment of collections methodologies with compensation plans
Security

- Control Over Volumes
- Monthly Cash Flow Needs
- Balance with culture, sustainability, competitive salaries and overall productivity performance
Production Incentives

- Creates compensation correlation to current collection methodology
- Balance with Security and Group Culture – some well established groups prefer 100% productivity
- Keep in mind the change to value based reimbursement and the need to introduce new types of structures to align with future collection methodologies
Strategic Initiatives

- Physician Retention
  - Competitive Salary Opportunity
  - Eliminate Payer Mix Penalties
  - Understand Culture and Strategic Initiatives of the group

- Service Line Development
  - Need for cross coverage of specialists
  - Consider individual physicians
  - Determine capacity trend
New Hire & 3rd Year Practitioner

- Initial hire considerations
  - New to the area, often 1-2 years of salary guarantee before moving to group model
  - Little or no prior experience
    - Reduced compensation, benchmarks available for those with limited practice experience
New Hire & 3\textsuperscript{rd} Year Practitioner

- \textbf{2\textsuperscript{nd} or 3\textsuperscript{rd} Year Practitioner}
  - Move to Group Compensation Plan
    - Model how plan will compensate employee using the past 6-12 months data
    - Review Group Compensation Plan annually to be sure it is meeting your strategic, financial and operational goals.
Competitive Sustainability & Fair Market Value

- Median Pay for Median Work
- Scalable but within Productivity to Salary benchmark ratios
- Must be sustainable for independent practices
- Must be within Fair Market Value for Not-for Profit practices
  - Sanctions
  - Exclusion from Medicare
Fair Market Value

- Fair Market Value must match Compensation Benchmarks with WRVU Benchmarks for the same year.

- Common misunderstanding in Employed Models:
  - Production per WRVU incentive is the same RVU used to set the base – See Example
  - Any WRVU table is acceptable with compensation
  - Fair Market Value is what someone is willing to pay.
Common Compensation Plans

- Independent Practices
  - Eat what you Kill – Collections Based

  - Collections pooling with redistribution through production measure, eliminating payer mix casualties – RVU or % of Charges Based

  - 100% equally shared expenses

  - **Equally shared** expenses for fixed overhead, **variable overhead** allocated by production measurement
Common Compensation Plans

- Employed Practices
  - Base Plus Production and/or Performance incentives Model with True Up
  - 100% Productivity
    - Trailing 3-12 months
    - % of historical Production with True Up
  - RVU Based Incentives
    - Must have modifier reductions
    - Must have true bundled service reductions
  - 100% Salary Model
REGULATORY AND COMPLIANCE OVERVIEW
Coding & Compliance

- Not new, but significant, ongoing financial losses or exposure to fines and sanctions
  
  - Periodically Audit each practitioners coding; can benchmark against national bell curve for outliers – in house and outside Audits

  - Provide a structure for continual feedback to practitioners such as formal quarterly meetings with biller

  - Periodic formal third party education
HIPAA

- Also not new, but continually monitored and sanctioned for violations.

  - Multiple sources for compliance standards
    - MGMA HIPAA Security Risk Analysis Tool
    - Malpractice Carrier Tools
Multiple tools and products available.

In Washington State, WISHA standards are enforceable and not exactly the same as OSHA, be sure to get a WISHA specific tool.
SGR Repeal

- End of the SGR inflationary penalty
- Provides a five year stability window of 0.5% conversion factor increases
  - First increase in July 2015
  - Second increase in January 2016
- 2020-2025 Fee Schedule rates will be maintained although adjustments through MIPS and APMs may be applied
SGR Repeal

- MACRA – Medicare Access and CHIP Reauthorization Act
  - Introduces MIPS – Merit Based Incentive Payment System
  - Introduces APM – Alternative Payment models that will be exempt from MIPS
SGR Repeal

- Meaningful Use (MU), Physician Quality Reporting System (PQRS) and Value Based Payment Modifier (VBPM) sunset in 2018.

- Merit Based Incentive Payment System (MIPS) goes into effect in 2019
  - Not yet defined but will be based on Quality, Resource Use, EHR Meaningful Use and Clinical Practice Improvement Activities.
Current Payment Adjustments

- PQRS – Physician Quality Reporting System
  - Can be claims based or attestation based reporting.
  - Must participate to avoid 2% payment reduction in 2017 for all practices.
  - 2014/2016 was the final year for a bonus under PQRS.
VBPM – Value Based Payment Modifier

- High Cost, Low Quality reduction up to 2% - in addition to the PQRS penalty

- Low Cost, High Quality incentive up to 2% Bonus

- Must have qualified in PQRS or other official CMS quality reporting metric program to be eligible for incentive
VBPM Timing

- PQRS qualification in 2013 for 2015
  VBPM: group practices with 100 or more eligible professionals (EPs)

- PQRS qualification in 2014 for 2016
  VBPM: group practices with 10 or more EPs

- PQRS qualification in 2015 for VBPM in 2017: all Medicare FFS physicians
VPBM Resources

- MGMA
  - The Value Based Payment Modifier: How to Prepare your practice
  - PQRS/VBPM Survival Guide
  - Both have multiple links into CMS source documents and all qualified CMS reporting programs
Meaningful USE

- Two Meaningful Use stages in 2015 Stage 1- 18 criteria and Stage 2- 20 criteria.

- Penalty for not meeting criteria in 2015 will be 3%, applied in 2017.

- Proposed legislation to ease meaningful use criteria to be finalized later this summer.
ICD 10

- Delayed until October 2015
  - Education
  - Anticipated concerns
    - Documentation of diagnosis in chart note, diagnosis selections vastly different
    - If converts education & documentation properly, no actual anticipated income losses
    - Potential short term cash flow disruptions as all systems convert – industry leaders say prepare for 90 days.
Current Bonus/Penalties

- **2014 (2016)**
  - PQRS 2%; MU 2%; VBPM 2%

- **2015 (2017)**
  - PQRS 2%; MU 3%; VBPM 4%

- Sunset of current plans to MIPS
New Bonus/Penalties

- **MIPS**
  - 2019 4% bonus/penalty
  - 2020 5% bonus/penalty
  - 2021 7% bonus/penalty
  - 2022 and beyond 9% bonus/penalty
MIPS

- Introduces bonuses as well as penalties back into the formula
- Criteria not established yet, but will be published in advance
- CMS will consult with specialty societies before establishing criteria
- Special consideration will be given to rural and small practices
- Annual improvements will be taken into consideration
Speaker Information

Lisa Marsh
Sound Medical Consulting, LLC
Bellevue, WA

Office: 425-406-8490
Cell: 360-790-1702

Email: lisa@soundmedicalconsulting.com