**MACRA Reporting for 2018 Services**

Ready or not, practices have to begin preparing for MACRA reporting for 2018 services.

**Despite only having to report ‘Something’ for 2017 services only 91% of the qualified (targeted) practices reported ‘Something.’ This means that 9% did not report and will have a 4% reduction in Medicare reimbursement.**

**Failure to report 2018 data will result in additional reductions to reimbursement. This is serious and can literally cripple the financial health of practices.**

**In addition to a continuing reporting requirement, data will now be subject to retention and audits. You just can’t report ‘Something.’ You are now expected to report data and report properly.**

**We will try to help practices understand and report.**

**Reporting is on a 100% scale as follows:**

**50% of your score is based on reporting Quality Measures**

**25% is based on Promoting Interoperative Measures which has to do with using and reporting via electronic health records. Last year this was referred to as Advancing Care Information**

**15% is for Improvement Activties**

**10% is Cost Measures**

**We will discuss these individually but will start with Quality Measures**

**There is some good news if you understand it. You only have to score 15 out of 100 points in order to prevent reimbursement reductions. 50% of your score can be achieved by reporting six (6) Individual Quality Measures. If you properly report only six quality measures, you can comply.**

**You will receive a minimum of 3 points for each measure your report. The points are then adjusted based on the category weight of 50% and other adjustment factors.**

**The easiest way for small practices to capture Quality Measures is to adjust their fee tickers (superbills) to include data that should be captured. You can then run simple reports to aggregate data for reporting.**

**Reporting Quality Measures Samples**

Proper reporting requires that practices understand the Quality Measures to be reported. Some may appear straight forward but can be more complex upon review. Following are sample Quality Measures and potential problem areas.

**Quality Measures Example 1**

**Description**: Percentage of patients 18-75 years of age with diabetes who had hemoglobin A1c>9.0 % during the measurement period.

Potential Problem Areas:

1. 18-75 years means that you have to report on patients **regardless of their** **Medicare status** unless they are under 18 years of age or over 75 years of

age. Can your software report based on patient age? You can put this data on your Superbill next to the patient name or date of service.

1. The type of diabetes is not specified. Therefore, you must be able to report patients with Type 1, Type 2 or Other specified diabetes. One way to gather this data is by grouping these patients in the ranges E10.10 – E13.9. However, these do not include diabetes during pregnancy so you must also include patient with diabetes during the measurement period with diagnosis codes in the range O24.011- O24.83 Diabetes in Pregnancy, childbirth and the puerperium.
2. Most family and general practices will automatically request a hemoglobin A1c lab measurement when patients are diagnosed with diabetes. However, this measure requires that you document the lab result CPT gives you a way to do this, e.g.,..

CPTII 3046F Most recent hemoglobin A1c level greater than 9.0%. Here an important point is that CPTII 3046F is for the most **recent** count. If the level changed you must be aware of the change. Following are a couple of codes that practices should be aware exist.

CPTII3045 Most recent hemoglobin A1c (Hba1c) level 7.0-9.0%

CPT 3044F Most recent hemoglovin A1c (HbA1c) level less than 7.0%

If the measurements are taken, it could be of value to be able to compare the percentage of diabetic patients with hemoglobin counts above and below 9.0%

Charge (Superbill) Ticket Presentation

Diabetes Code:\_\_\_\_\_\_\_\_\_\_ (E10.10 through E13.9)

Gestational (diabetes during pregnancy) O24.0- O24.93

CPTII 3046F: \_\_\_\_\_\_\_\_\_\_\_\_ Hemoglobin A1c> 9.0%

Patient Age :\_\_\_\_\_\_\_\_\_\_\_\_ (18-75). This does not have to be entered into your billing system unless your software allows reporting based on age as of a date of service. You may also wish to use alternate codes which your practice agrees to use in conjunction specifically for MACRA reporting, e.g., Z00.129 Encounter for routine child health examination without abnormal findings. This code in conjunction with a diabetes code would indicate someone under 18 years of age without an abnormal Hemoglobin A1c count. For diabetic patients greater than 75 years without an abnormal Hemoglobin count, you may wish to use an additional ICD10 code such as R54 Age-related physical disability.

These codes can be presented in the normal manner, e.g., diagnosis codes are listed as with other diagnosis codes and CPT Codes are presented with other CPT codes.

Pitfalls:

**The most important point in meeting this MIPS reporting requirement is to make sure that patients diagnosed with diabetes have Hemoglobin A1c testing.**

Your billing system probably does not have CPTII codes. If not, you will have to add this code. If your software requires a billed amount, you can use $0.01 to cause the least effect on your accounts receivable totals.

Patient age can be a problem. Be sure patients are 18 years of age up to 75 years. Patients below and above this range should not be included.

The hemoglobin A1c test must have been taken during the measurement period (2018) and be 9.0% or higher to meet the CPTII code 3046F definition

If your billing software has report writer capabilities to isolate diagnosis codes by a range of codes, e.g. E10.10 – E13.9 and O24.0-O24.93 and

Report by CPT (3046F) during a range of dates and

Specify a patient’s age during the measurement period. Then, you should be able to report this MIPS measure. However, it is important to not include patients outside the age range. Check with your software vendor if you are not sure of reporting capabilities.

In Summary

A Count the number of patients with a diagnosis of diabetes E10.10 – E13.0 and O24.0 – O24.93

B. Count the number of patients with CPTII3046F

C. Remove from the number computed in A, any patients below 18 years of age and any over 75 years of age

B /( A-C) = percentage of diabetic patients with a Hemoglobin A1c count

Above 9 %.

Remember you have to retain a record of these patients but your billing system can probably do the job.

**Most practices will only have to add CPTII Code 3046F to their charge ticket in order to report this Quality Measure**

Please note that Quality Measures can assist your practice in other ways. As an example, a doctor has expressed concern that if he specifies certain patients with abnormal hemoglobin A1c counts, he may be criticized for not doing more to help them reduce this level because certain patients don’t take care of themselves and it can be difficult to have them cooperate. A good response to this concern is to refer Medicare patients to Chronic Care Management.

**Chronic Care Management**

Chronic Care Management is a new Medicare **program that Pays Providers who refer patients to this program**. The program consists of trained professionals who get paid to call patients who have been referred to the program. The patients are contacted for a telephonic check on their condition. They are questioned on their health status and are encouraged to see their provider if they haven’t been seen or may benefit from seeing their doctor. Medicare encourages this because of cost savings that result from avoiding ER and/or hospital encounters. **Providers who use this program can also report this as an Improvement Activity to increase their MACRA reporting scores. We will discuss this in later editions.**

Patients are called on a monthly basis. The provider receives a payment of about $42 per patient per call. The provider is then billed about $25 per patient per call for the service. This amounts of a win-win for patient, provider and Chronic Care program providers.

**For information on Chronic Care and how to participate, please contact us.**

**Contact: Dr. Donna Meeks- 661-209-2782 or e-mail us at mfbizdev@gmail.com**

**Quality Measures Example 2**

**Description: Percentage of patients 18 years and older with a BMI documented during the current encounter or during the previous six months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous six months of the current encounter.**

Body Mass Index (BMI) is defined as a person’s weight in kilograms divided by the square of height in meters. If your BMI falls within the normal if is within the range of 18.5 < 25, it is within the normal. If your BMI is 25.0 < 30, it falls within the overweight range. If your BMI is 30.0 or higher, it falls within the obese range.

Manual calculation of BMI can be done as follows:

1. Multiple your weight by 0.45
2. Multiple your height by 0.025
3. Square your answer from step 2
4. Divide the answer from step 1 by the answer from step 3

There are a number of free on-line BMI calculation tools that only require the patient’s height (feet and inches) and weight in pounds that will calculate the BMI. You can find these on the Internet via Google and other search tools.

This can be reported very simply by adding a few lines to your Charge Ticket (Super bill).

In the place for diagnosis codes enter ICD10 code Z68.1 through Z68.45. These are adult BMI codes for patients 21 years of age or older. If a patient is less than 21 years use an ICD10 code in the pediatric range of Z68.51 through Z68.54.

The existence of a code(s) from these ranges is documentation that a BMI measurement was taken.

CPTII code

4551F Nutritional support offered

If this code is used, it can be documentation that a follow-up plan was offered for patients with an abnormal BMI.

Reporting then becomes simple:

1. Count the number of patients with a diagnosis code in the range Z68.1 through Z68.54
2. Count the number of patients with CPTII 4551F
3. Divide the count in step 2 by the number in Step1 to give the reporting percentage.

**Just add two data elements to your charge ticket and you can report this measure.**

**It should be noted that Obesity is considered to be a Chronic Condition that can be reported under the Chronic Care Management Program**.

For Information on the Chronic Care Management Contact:

Dr. Donna Meeks 661-209-2782 or email us at mfbizdev@gmail.com

**Quality Measure Example 3**

**Description: Percentage of patients aged 18 years and older for which the eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL know prescriptions, over the counter, herbals and vitamins/mineral/dietary (nutritional supplements AND must contain the medications’ name, dosage, frequency and route of administration.**

Most providers have this documentation. When you write a prescription which factors in all the listed criteria you can simply add a single CPTII code as follows

CPTII Description:

1159F Medication list is documented in the medical record

Reporting then becomes a simple calculation. Count the number of patients with CPTII 1159F and divide this number by the number of patients seen during the measurement period (2018).

**You only have to add and use one CPTII code to report this Measure.**

**Quality Measure Example 4**

**Description: Percentage of patients 65 years of age and older who have ever received pneumococcal vaccine**

There are two Medicare covered pneumococcal vaccines

CPT Description

90670 Pneumococcal conjugate vaccine, 13 valent (PCV13), for intramuscular use and

90732 Pneumococcal polysaccharide vaccine, 23-valent (PPSV23), adult or immunosuppressed patient dosage, when administered to individuals 2 years or older subcutaneous or intramuscular use

**This Measure is easy to report, you only have to run a report of patients who have ever been billed for either CPT 90670 or 90732. You can then count the number of patients with either billed code and divide the total by the number of your senior patients.**

There are two caveats here. First CPT 90670 (Prevnar) is considered a once in a life time injection for patients who were of Medicare age at the time of injection. Therefore, a patient who had this injection last year is part of the population. Also, since this is a lifetime event, he or she should only have this billed once. You may have to go into past years to determine all these patients. If both codes 90670 and 90732 have been billed, this should be considered unusual and only one of these should be considered part of the total who received the vaccine.

**Quality Measure Example 5**

**Description: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention, if identified as a tobacco user**

As part of the normal interview process for patients, they should be asked if they smoke or use tobacco. If the answer is yes, one or more of the following diagnosis codes should appear in the patient record.

Z72.0 Tobacco use NOS

F17.2- Nicotine dependence

F17.2 Tobacco dependence

Q99.33- Tobacco use during pregnancy

If a patient received cessation counseling, provider can bill for this service.

CPT Description

99406 Smoking and tobacco use cessation counseling visit; Intermediate, greater than 3 minutes up to ten minutes

99407 ; intensive greater than 10 minutes

**This Measure can then be computed by counting the number of patients with the listed CPT codes divided by the number of patients with one or more of the diagnosis codes.**

**The only change to your charge ticket is to add CPT’s 99406 and 99407 if they do not currently appear. Both Medicare and private carriers cover this service.**

There are a number of CPTII codes relevant to this Measure but are not needed in order to report: 1000F Tobacco use assessed

1031F Smoking status and exposure to second hand smoke in the home assessed

1032F Current tobacco smoker or currently exposed to second hand smoke

1034F Current tobacco user

Please note that measure is for tobacco use and not just smoking. If a patient chews tobacco diagnosis codes F17.2- (tobacco dependence) and/or Z72.0 Tobacco use NOS may be appropriate.

If you bill for cessation, the related billing diagnosis should be one for Tobacco use.

**Quality Measure Example 6**

**Description: Percentage of patients, aged 18 years or older, with a diagnosis of acute sinusitis who were prescribed an antibiotic within 10 days after onset of symptoms**

Acute sinusitis is described by diagnosis codes in the range J01.00 – J01.91

Antibiotic dispensation or prescription can is specified by CPTII code 4120F

Code Description

4120F Antibiotic prescribed or dispensed

In order to report this Measure, practices may have to add CPTII 4120F to their charge tickets.

Reporting simply consists of counting the number of patients with a diagnosis in the range J01.00 through J01.91 and dividing this total into the number of patients with CPTII 4120F It should be noted that Medicare thinks medication use is a potential problem.

**For most practices this Measure just requires the addition of CPTII 4120F to their charge ticket.**

**SUMMARY OF LISTED MEASURES**

Most Family and General Practices can meet 2018 MACRA Reporting Requirements by using the methodology enumerated above.

In addition, the **Measures listed above do not require the use of an electronic health record system.**

**Small practices can comply. There are some additional steps required for reporting and we will discuss these in the near future.**

**The main thing for practices is to start collecting the data needed for reporting by adjusting their charge tickets and having a practice awareness of what they are to report and making sure that appropriate diagnosis and CPT codes are used.**