January 2017

For Your 2017 "To Do" List

With the start of a new year, many payment and practice management tasks get reset and new ones get added to our To Do lists. It does seem that very few drop off and 2017 is no exception to that! In this first Timely Topic for 2017, we will cover three items that should be near the top of your list.

Collect Patient Deductibles
Deductibles have long been a part of a patient's insurance coverage. In a patient-focused publication from the Centers for Medicare and Medicaid Services (CMS) (Medicare & You 2017) a deductible is defined as *"the amount you must pay for health care or prescriptions before Original Medicare, your prescription drug plan, or your other insurance begins to pay."* This is the amount that the patient (or in some cases a supplemental plan) must pay out of pocked before Medicare Part B starts to issue payments for covered services. Once a patient has met the deductible, the patient's financial responsibility is either the copayment or coinsurance. Per Medicare & You:

- Coinsurance: An amount you may be required to pay as your share of the cost for service after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%)
- Copayment: An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

Deductibles typically run on a calendar year. When you provide care early in the year, it is quite possible that some or all of the allowed payment will be applied to the deductible. Your practice's Days in Accounts Receivable metric may creep up as a result – particularly if your billing/collection functions do not pursue timely collection of these deductibles. These collection efforts have become even more important in recent years since the amount assigned to deductibles has been rising steadily.

Medicare Part B Deductible	
2015	$147
2016	$166
2017	$183

In the private payer sector, high-deductible health plans (HDHP) have deductibles of ≥$1,300 for an individual or ≥$2,600 for a family. [1]

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[1] https://www.healthcare.gov/glossary/high-deductible-health-plan/

Prepare for MIPS Reporting

January 1, 2017 marks the start of the first performance period for the Merit-based Incentive Payment Program (MIPS). MIPS is part of the Quality Payment Program (QPP) under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). One of the main elements of MACRA is the elimination of the flawed Sustainable Growth Rate (SGR) formula that was such an important part of determining Medicare payments. Take the time to learn what/how you will need to report on Quality, Advancing Care Information and Improvement Activities under MIPS to avoid a negative payment adjustment in 2019 and become eligible for a positive adjustment. A great place to start is http://www.asahq.org/quality-and-practice-management/macra

Report on Visits within a Global Period

Certain physicians and other healthcare providers who perform selected services that have a 10 or 90-day global period will be required to submit information-only claims to CMS to create a record of follow up visits during the assigned global period. A September 2016 Timely Topic described details of how CMS *proposed* to implement this new MACRA-mandated requirement. There were some very significant changes between what was proposed and what was *finalized*.

CMS has proposed making this reporting mandatory for ALL practitioners on all services with a 10 or 90 day global period. As finalized, the requirement pertains only to those who practice in specified states and be required for services that meet certain utilization thresholds. Details will be discussed on the February 2017 ASA Monitor in the Payment and Practice Management column. This reporting becomes required on July1, 2017; take the time now to learn what this will involve.