ORIGINAL ARTICLE

The Proposed MACRA/MIPS Threshold for Patient-Facing Encounters: What It Means for Radiologists

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Abstract

Purpose: In implementing the Merit-Based Incentive Payment System (MIPS), CMS will provide special considerations to physicians with infrequent face-to-face patient encounters by reweighting MIPS performance categories to account for the unique circumstances facing these providers. The aim of this study was to determine the impact of varying criteria on the fraction of radiologists who are likely to receive special considerations for performance assessment under MIPS.

Methods: Data from the 2014 Medicare Physician and Other Supplier file for 28,710 diagnostic radiologists were used to determine the fraction of radiologists meeting various proposed criteria for receiving special considerations. For each definition, the fraction of patient-facing encounters among all billed codes was determined for those radiologists not receiving special considerations.

Results: When using the criterion proposed by CMS that physicians will receive special considerations if billing ≤25 evaluation and management services or surgical codes, 72.0% of diagnostic radiologists would receive special considerations, though such encounters would represent only 2.1% of billed codes among remaining diagnostic radiologists without special considerations. If CMS were to apply an alternative criterion of billing ≤100 evaluation and management codes exclusively, 98.8% of diagnostic radiologists would receive special considerations. At this threshold, patient-facing encounters would represent approximately 10% of billed codes among remaining radiologists without special considerations.

Conclusions: The current CMS proposed criterion for special considerations would result in a considerable fraction of radiologists being evaluated on the basis of measures that are not reflective of their practice and beyond their direct control. Alternative criteria could help ensure that radiologists are provided a fair opportunity for success in performance review under the MIPS.

Key Words: health policy, radiology, radiologists, Medicare, payment reform

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INTRODUCTION

The recently introduced Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) heavily ties physician payments to the quality and efficiency of care [1]. For most physicians, payments under MACRA will be determined using the Merit-Based Incentive Payment System (MIPS). MIPS incorporates a wide range of performance measures that collectively will form the basis for positive or negative payment adjustments [2-4]. We separately describe in greater detail CMS's proposed framework for performance assessment and payment modification under MIPS [5].

Many of the MIPS performance measures are most relevant to physicians with frequent face-to-face patient interactions, as is typical, for example, of primary care practitioners. However, to ensure that MIPS assesses

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physicians on the basis of measures relevant to their practice, statutory requirements of MACRA require that CMS grant special considerations to physicians with infrequent face-to-face patient interactions [1]. To fulfill such requirements, CMS proposes modifying the derivation of the MIPS composite performance score for those physicians with infrequent fact-to-face patient interaction, including both altering the weighting of performance categories as well as changing the specific reporting requirements within individual performance categories [2]. Such modifications will be important to ensure that all physician specialties have a fair opportunity to achieve success under this new quality program. Specifically, CMS has recently proposed granting such special considerations to physicians with no more than 25 patient-facing encounters in a billing cycle [2]. Patient-facing encounters include office visits, outpatient visits, and surgical procedures, with the first two of these categories represented by evaluation and management (E&M) codes and the third category intended to be further defined by a specific, though yet to be released, list of Current Procedural Terminology codes (expected to be released in late 2016) [2]. However, numerous physician groups [6,7] are concerned that this definition will result in many practitioners for whom face-to-face patient interactions are a very small portion of their practice, and thus who would most appropriately be evaluated using alternative criteria, instead being excluded from the special considerations and subject to the standard MIPS performance measures.

The ACR [7], American Society of Neuroradiology [8], and the Society of Interventional Radiology [9] have recommended to CMS that the language "non-patient-facing" not be used to describe MIPS eligible clinicians and have also recommended alternative criteria and thresholds for when such clinicians could receive special considerations. It is not known at the time of this writing whether CMS can or will alter the descriptive language used in the statute, nor is it known whether CMS will alter the proposed regulatory criteria for such special considerations. Recommendations for altering the CMS proposed definition include first to raise the threshold in terms of the number of patient-facing encounters from >25 (corresponding with only approximately two face-to-face patient encounters per month) to >100 (corresponding with CMS's proposed "low-volume" patient care threshold for determining a clinician to be eligible for MIPS [7]). Second, it is suggested to define patient-facing encounters solely in terms of codes for office and outpatient visits, while excluding codes for surgical procedures. The latter category includes codes for a diverse range of interventions, including, for example, image-guided thoracentesis, paracentesis, and biopsy. Radiologists commonly perform such procedures in accordance with a referring physician's order, without also seeing the patient in consultation before or after the procedure or maintaining a separate clinic to provide any associated patient management. The ACR particularly advises excluding as patient-facing encounters those surgical codes corresponding with a 0-day global period (hereafter referred to as [000] day global codes), as opposed to codes corresponding with 10- or 90-day global periods (hereafter referred to as [010/090] day global codes) in which postoperative care is, by definition, included in the upfront payment.

CMS will use Medicare administrative claims data to determine clinicians' eligibility for special considerations, as claims data represent the only objective source of this information. Thus, past claims data could likewise be applied to explore radiologists' practice patterns and gain insights into their likelihood of receiving special considerations. The purpose of this study was to use claims data to determine the impact of varying criteria on the fraction of radiologists who are likely to receive special considerations for performance assessment under MIPS.

METHODS

We used solely publicly available administrative data provided by CMS. Because no private identifying information was used, this did not represent human subjects research, and institutional review board approval was not required. The 2014 Medicare Provider Utilization and Payment Data: Physician and Other Supplier file was obtained from CMS [10]. This file contains 100% of Part B noninstitutional claims for the Medicare fee-for-service population, excluding beneficiaries in Medicare Advantage. Data includes physicians' names, self-reported specialties, as well as the number of services performed for Medicare beneficiaries stratified by Healthcare Common Procedure Coding System (HCPCS) code. Physicians or their office credentialing staff members enter the self-reported specialty at the time of initial enrollment in the Medicare system using the online Provider Enrollment Chain and Ownership System (PECOS) [11]. All physicians with a primary self-reported specialty of diagnostic radiology or interventional radiology were considered to represent radiologists and included in this analysis.

E&M codes of potential relevance to radiologists (992xx-994xx) were included in the analysis. Because