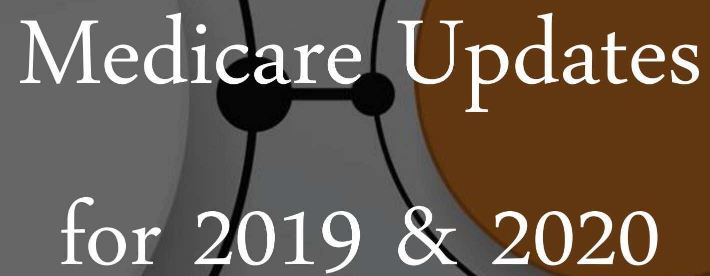

Medicare Updates for 2019 & 2020

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Agenda

- Updates to the OPPS for 2019
- Updates to the PFS for 2019 and beyond
- Changes to the laboratory reporting requirements

- Expansion of Comprehensive APCs
- Changes to Device-Intensive Procedures
- Changes to Inpatient-Only Procedures
- New Pass-Through Device
- Payment for Outpatient Clinic Visits at PBDs
- Data Collection for Off-Campus Provider-Based Emergency Depts
- 340B Payment Policy for Nonexcepted Off-Campus PBDs
- Update on 340B Lawsuit

Comprehensive APCs (C-APCs)

- CMS established C-APCs in 2015
- HCPCS codes which are assigned to C-APCs receive a bundled payment that includes mostly everything on the claim (some items are excluded from bundling such as preventive services, pass-through drugs/devices, etc.)
- The number of procedures assigned to comprehensive APCs has expanded significantly since their introduction

Comprehensive APCs (C-APCs)

- Three new C-APCs established for 2019
  - 5163 Level 3 ENT Procedures
  - 5183 Level 3 Vascular Procedures
  - 5184 Level 4 Vascular Procedures
- Adds 183 more comprehensive procedures
- As of January 1, 2019 there are now 2,905 total HCPCS codes assigned to comprehensive APCs

Device Intensive Procedures

- Procedures where the cost of a device represent a significant portion of the procedure's APC payment rate (>40% of APC rate)
- Device must be surgically implanted/inserted and remain in patient's body at conclusion of procedure
- Device intensive HCPCS codes are subject to device dependency edits (device code must be reported on claim) and reporting of device credits (must report value code FD on claim when credit received for 50% or more of cost of the device)

Device Intensive Procedures

- Two important changes to definition of device intensive procedures for 2019

1. Device does not need to remain in the patient’s body
2. Cost threshold is lowered to 30% of APC payment rate

- This more than doubles the amount of device intensive procedures subject to device edits and device credit reporting, from 181 to 358

- See Addendum P of the OPPS Final Rule for the complete list

Inpatient Only Procedures

- HCPCS codes are assigned status indicator “C” and are only payable by Medicare in the inpatient setting

- Four procedures are removed from the inpatient-only list for 2019

31241 - Nasal/sinus endoscopy, surgical; with ligation of sphenopalatine artery

01402 - Anesthesia for open or surgical arthroscopic procedures on knee joint; total knee arthroplasty

0266T - Implantation or replacement of carotid sinus baroreflex activation device; total system

00670 - Anesthesia for extensive spine and spinal cord procedures

Inpatient Only Procedures

- Does not mean that procedures cannot be performed in IP setting – can be performed in IP or OP setting depending on what is appropriate for the patient

- One procedure is being added to the inpatient only list for 2019

C9606 - Percutaneous transluminal revascularization of acute total/subtotal occlusion during acute myocardial infarction, coronary artery or coronary artery bypass graft, any combination of drug-eluting intracoronary stent, atherectomy and angioplasty, including aspiration thrombectomy when performed, single vessel/sinus endoscopy, surgical; with ligation of sphenopalatine artery

New Pass-Through Device

- New pass-through device category has been established for reporting the remedē® System Transvenous Neurostimulator

- Implantable phrenic nerve stimulator indicated for the treatment of moderate to severe central sleep apnea (CSA) in adult patients

C1823 - Generator, neurostimulator (implantable), non-rechargeable, with transvenous sensing and stimulation leads

- Associated procedure is reported with CPT 0424T

Payment for Outpatient Clinic Visits at PBDs

- CMS has expressed concern over the significant growth in Medicare spending
- The OPPS has been the fasting growing sector of Medicare payments out of all payment systems under Medicare Parts A and B (8.6% annual increase, with spending doubling in last decade)
- CMS believes a large portion of the spending growth is due to the extra reimbursement received by provider-based outpatient departments of hospitals

Payment for Outpatient Clinic Visits at PBDs

- CMS previously implemented the requirements of Section 603 of the Bipartisan Budget Act of 2015 which reduced the payment of services furnished at off-campus PBDs established after 11/2/2015
- Payment is made at the PFS equivalent rate instead of under the OPPS (PFS-equivalent rate = 40% of OPPS rate, or 60% reduction)
- However, the majority of off-campus PBDs are grandfathered (excepted from the payment reduction) and report services with PO modifier and still receive higher OPPS payment rates

Payment for Outpatient Clinic Visits at PBDs

- CMS finalized a “method to control unnecessary increases in the volume of OP services” in the 2019 Final Rule
- OP clinic visits (reported with HCPCS G0463) provided at excepted off-campus PBDs (those reporting modifier PO and still receiving higher OPPS payment rates) will now received the reduced PFS-equivalent rate
- This reduction is being applied in a **non-budget neutral** manner (cost savings will not be redistributed throughout the OPPS)

Payment for Outpatient Clinic Visits at PBDs

- Reduction is being phased in over 2 years
- For CY 2019 payment for G0463 with PO modifier is reduced by 30%
- For CY 2020 payment will be reduced by 60%

Code	Description	CY 2018 Payment	CY 2019 Payment	%Diff
G0463	Hospital outpatient clinic visit	$113.69	$79.58	-30%

Data Collection for Off-Campus Provider-Based Emergency Depts

- CMS is also concerned with the growth in providers establishing off-campus emergency departments, which also receive higher OPPS payments

- Effective 1/1/2019 CMS requires that all services provided in off-campus provider-based emergency departments be reported with informational modifier “ER”

ER – Items and services furnished by a provider-based off-campus emergency department

- CAHs are not required to report this new modifier

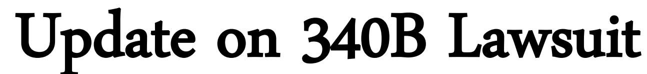
340B Payment Policy for Nonexcepted Off-Campus PBDs

- Since 1/1/2018 payment rate under OPPS for drugs acquired under the 340B Program has been average sales price (ASP) minus 22.5%
- This was a major reduction to the previous payment rate of ASP + 6%
- Off-campus PBDs that are not excepted from section 603 of the BBA are no longer paid under the OPPS, but rather under the “alternate payment system” (PFS-equivalent rate)
- Because drugs provided in these locations are not paid under the OPPS, the 340B payment reduction has not applied and they have continue to be paid at the higher ASP +6% rate

340B Payment Policy for Nonexcepted Off-Campus PBDs

- CMS feels that this undermines the goals of the original payment reduction and could result in behavioral changes by providers (e.g., furnishing drugs in the setting which provides the highest reimbursement)

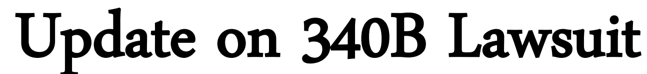
- To continue push towards site neutrality, CMS finalized a policy effective 1/1/19 where drugs acquired through 340B and furnished at nonexcepted off-campus PBDs will also be paid at the ASP minus 22.5% rate, even though they are not paid under the OPPS



- On December 27, 2018 in *The American Hospital Association, et. al. v. Azar*, the U.S. District Court for the District of Columbia issued a permanent injunction to the CMS payment reductions finalized in the 2018 OPPS Final Rule

- Decision stated that CMS exceeded their authority in implementing this cut

- Court declined to vacate the rule and award payment to the plaintiffs due to the drastic implications to Medicare's complex administration



- Judge ordered the two sides to file supplemental briefs to address the question of a proper remedy

- Did not block payment reductions from being applied for CY 2019 and did not address new policy finalized regarding nonexcepted off-campus PBDs

- Final results are TBD

PFS Updates for 2019 and Beyond

- E&M Documentation and Payment Changes
- Functional Reporting Requirements
- Payment for Rehab Services Provided by Therapy Assistants
- Telehealth Updates
- New Non-face-to-face Services
- Changes to the Laboratory Reporting Requirement

E&M Documentation and Payment Changes

- Major changes due to CMS' "Patients Over Paperwork" initiative
- Initiative's goal is to evaluate/streamline regulations to reduce unnecessary burden, increase efficiencies, & improve beneficiary experience
- Providers expressed to CMS that the E&M documentation guidelines and code set are clinically outdated and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care
- Also, guidelines may not be reflective of changes in technology or the way that EMRs have changed documentation and the patient's medical record and some aspects of required documentation are redundant

E&M Documentation and Payment Changes

- Significant changes were proposed in the 2018 PFS Proposed Rule
- CMS finalized their proposal with modifications, but delayed some of the changes until 2021
- For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E&M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E&M documentation guidelines
- A few changes were finalized beginning in CY 2019

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit

- For history and exam for established patients, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and do not need to re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed

- Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so

Finalized Changes for 2019

- For chief complaint and history for new and established patient visits, practitioners do not need to re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary
- The practitioner may simply indicate in the medical record that he or she reviewed and verified this information
- Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians

Additional Changes Starting in 2021

- Single payment rates for levels 2 through 4 for established & new patients, maintaining the payment rates for level 5 in order to better account for the care and needs of complex patients
- Permitting practitioners to choose to document E&M office/outpatient level 2 through 5 visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework
- For level 2 through 4 visits, when using MDM or current framework to document the visit, CMS will apply a minimum supporting documentation standard associated with level 2 visits

Additional Changes Starting in 2021

- When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary

- New add-on codes for level 2 through 4 visits will describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care

- Adoption of a new “extended visit” add-on code for use with level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient

Source: CMS.gov
E&M Payment Chart

	Complexity Level under CPT	Current (2018) Payment Amount: Visit Code Alone*	Revised Payment Amount***: Visit Code Alone Payment	Revised Payment Amount***: Visit Code With Either Primary or specialized care add-on code**	Revised Payment Amount***: Visit Code with New Extended Services Code (Minutes Required to Bill)	Revised Payment Amount***: Visit with Both Add-on and Extended Services Code Added**	Revised Payment Amount***: Current Prolonged Code Added (Minutes Required to Bill)*
New Patient	Level 2	$76	$130	$143	$197 (at 38 minutes)	$210	
	Level 3	$110					
	Level 4	$167					
	Level 5	$211	$211				$344 (at 90 minutes)
Established Patient	Level 2	$45	$90	$103	$157 (at 34 minutes)	$170	
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				$281 (at 70 minutes)

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.
Physician groups have routinely complained to CMS that billing prolonged with any regularity tends to prompt medical review and is ultimately cost-prohibitive.
**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.

***The dollar amounts included in this projection are based on 2019 payment rates; actual amounts in 2021 when the policy takes effect will differ.

- After consideration of comments received regarding the proposed rule, CMS will not finalize the following proposed changes:

- Reduced payment when E/M office/outpatient visits are furnished on the same day as procedures

- Separate coding and payment for podiatric E/M visits

- Standardizing the allocation of practice expense RVUs for the codes that describe these services

Functional Reporting Requirements

- CMS has required functional reporting related to outpatient rehab services since 2013
- The data from the functional reporting system was to be used to aid CMS in recommending changes and reforming of Medicare payment for outpatient therapy services
- The data has not been effective for CMS to use and has been burdensome for providers
- CMS has discontinued functional reporting requirements effective 1/1/2019

- The Bipartisan Budget Act of 2018 requires payment for services furnished in whole or in part by a therapy assistant at 85 percent of the applicable Part B payment amount for the service effective January 1, 2022

- CMS has established two new modifiers – one for Physical Therapy Assistants (PTA) and another for Occupational Therapy Assistants (OTA) – when services are furnished in whole, or in part by a PTA or OTA

- Reporting of modifiers will be mandatory effective 1/1/20, although payment reduction is not effective until 1/1/22

Payment for Rehab Services Provided by Therapy Assistants

- PTA Modifier CQ: Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant
- OTA Modifier CO: Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant
- These are *payment* modifiers, not therapy modifiers, and must be reported in conjunction with existing rehab modifiers (GP, GO)
- Finalized standard where service is furnished in whole or in part by a PTA or OTA when >10% of the service is furnished by the PTA or OTA, instead of the proposed definition that applied when a PTA or OTA furnished any minute of a therapeutic service

Telehealth Updates

- Accepting codes G0513 and G0514 for prolonged preventive services performed via telehealth

- ESRD related clinical assessments

  - Adding renal dialysis facilities and homes of ESRD beneficiaries receiving home dialysis as originating sites

  - Removing originating site geographic requirements for hospital-based or CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes

Telehealth Updates

- Adding mobile stroke units as originating sites
- Not applying originating site type and geographic requirements for telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke

Telehealth Updates

- Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder and Other Substance Use Disorders

- Through an interim final rule, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019

Non-face-to-face Services

Virtual Check In (G2012)

- Brief non-face-to-face check-in w/ patient to determine if an office visit is warranted
- Helps to mitigate the need for unnecessary office visits
- If check-in is related to E&M service provided by same provider w/in last 7 days, or results in a E&M visit w/ provider, not separately billable
- Need to obtain patient's consent to provide this service

Remote Evaluation of Pre-Recorded Patient Information

Remote Evaluation of Pre-Recorded Patient Information (G2010)

- Remote evaluation of recorded video and/or images submitted by the patient (e.g., store and forward), including interpretation with verbal follow-up with the patient within 24 business hours
- Similar goal to avoid unnecessary office visits
- Not billable if related to E&M visit with same provider w/in 7 days, or if results in E&M visit with provider

Interprofessional Consultation

- Describe services conducted through telephone, internet, or EHR consults when patient's treating physician requests opinion and/or advice of a consulting physician with specific expertise to assist with the diagnosis and/or management of the patient's problem

- Recommendation from AMA RUC for CMS to pay for four existing internet consultation codes (99446-99449) plus two new codes (99451-99452) which include the work of the treating physician when initiating a consult

- Patient consent will be required to perform these services

Changes to the Laboratory Reporting Requirement

- On June 17, 2016 CMS published its final rule implementing section 16 of the Protecting Access to Medicare Act of 2014 (PAMA) , which added a new section, 1834A, to the Social Security Act

- Requires applicable laboratories to report private payor rates paid for clinical diagnostic laboratory tests (CDLTs) to CMS so they can be used to calculate Medicare payment rates

Changes to the Laboratory Reporting Requirement

CMS made two revisions to the regulatory definition of applicable laboratory:

1) Medicare Advantage plan revenues are excluded from total Medicare revenues, the denominator of the majority of Medicare revenues threshold

2) Hospitals that bill for their non-patient laboratory services use Medicare revenues from the Form CMS-1450 14x Type of Bill (TOB) to determine whether its hospital outreach laboratories meet the majority of Medicare revenues threshold and low expenditure threshold

Changes to the Laboratory Reporting Requirement

- Hospital outreach laboratories will most likely meet the majority of Medicare revenues threshold because their Medicare revenues are primarily derived from the CLFS and or PFS
- Must meet low expenditure threshold of $12,500 in a data collection period (January 1, 2019 through June 30, 2019)
- SE19006 Dated February 27, 2019

Questions?

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