SATINSKY CONSULTING

WINTER 2019 NEWSLETTER

On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) finalized the 2019 Physician Fee Schedule and quality reporting programs. The final rule, effective January 1, 2019, updates both the Merit-based Incentive Payment System (MIPS) and alternative payment model (APM) payment options and requirements for the current calendar year. If you would like background information on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and on changes since the passage of that original legislation, see our Winter 2018 Newsletter. Our Late Fall 2018 Newsletter highlights proposed changes for 2019, not all of which were incorporated into the final rule.

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FINAL 2019 MEDICARE PHYSICIAN PAYMENT AND QUALITY REPORTING CHANGES

Changes to Physician Payment

CMS has made many important changes to physician payment, evaluation and management (E/M) coding, Part B drugs, and appropriate use criteria for advanced diagnostic imaging services. Here are the highlights.

1. **Physician Conversion Factor:** The 2019 Medicare PFS conversion factor will increase from $35.9996 in 2018 to $36.0391 in 2019. The change includes the 0.25% update required by the Bipartisan Budget Act of 2018. The budget neutrality adjustment is now -0.12%. For anesthesiologists, the conversion factor is $22.2730.

2. **Physician Billing for Communication through Technology:** In recognition of the trend toward increased physician-patient communication through technology, CMS will pay for two new services for established patients of physicians who independently bill Medicare for E/M visits, subject to restrictions. The first new service is a **brief non-face-to-face appointment** (i.e. virtual check-in by telephone or other means) using HCPCS code G2012. The second new service is the **evaluation of patient-submitted images or video and subsequent follow up** using HCPCS code G2010. Neither the virtual check-in nor the evaluation of patient-submitted images or video and subsequent follow-up can originate from a related E/M visit provided within the previous seven days nor lead to an in-person visit within 24 hours or soonest available appointment. Patients must provide written consent prior to each of the two new services and are responsible for any co-insurance.

3. **Physician Billing for Inter-professional Consultations:** Two new codes, CPT codes 99451 and 99452, will allow physicians to bill for inter-professional internet/telephone consultations between a treating practitioner and a consulting practitioner. Existing CPT codes 99446, 99447, 99448, and 99449 will be unbundled. As with the items listed in #2 above, practitioners must obtain and document beneficiary prior consent, and beneficiaries are responsible for any copayments.

4. **Remote Patient Monitoring:** Expanding its 2018 efforts to provide coverage for remote patient monitoring, CMS has added three new chronic care remote physiologic monitoring codes, CPT codes 99453, 99454, and 99457. Clarification of the types of technology that will qualify for remote monitoring is forthcoming.

5. **Medicare Telehealth Services:** CMS is gradually shifting its interpretation of "Medicare telehealth services." Historically, Section 1834 of the Social Security Act, which defines "Medicare telehealth services", has restricted coverage to beneficiaries who are located at specific and limited site categories. Two new codes, HCPCS G0513 and G0514, are subject to these restrictions. Seeking to work around the restrictions on Medicare coverage for telehealth services, CMS has made changes permitted or required by the Bipartisan Budget Act of 2018 (e.g. flexibilities for certain services related to end-stage renal disease home dialysis and acute stroke) and the SUPPORT for Patients Act of 2018. With respect to this second act, CMS has removed geographic requirements and added a beneficiary's home as a permissible originating site for telehealth services furnished for the purpose of treating substance use disorder or co-occurring mental health disorder for services furnished on or after July 1, 2019.

6. **Evaluation and Management (E/M) Services:** The initial CMS proposal to reduce documentation requirements and alter coding and payment generated a mixed reaction from major interest groups. In response to concerns raised, CMS has agreed to put the documentation changes into effect in 2019 and delay the coding and payment changes until 2021. CMS has not finalized its proposal regarding reimbursement when office/outpatient visits are furnished on the same day as procedures.

    - **Documentation:** Effective January 1, 2019, practitioners are no longer required to re-record elements of the history and physical exam when there is evidence that the information has already been reviewed and updated. Practitioners must document only that they reviewed and verified information about the chief complaint and medical history that has already been recorded by ancillary staff or the beneficiary. They no longer need to document the medical necessity of providing a home rather than an office visit. Finally, the presence and participation of a teaching physician can be demonstrated by notes in the medical record made by a physician, resident, or nurse.

- **Payment and Coding Policies:** Effective January 1, 2021, practitioners will have options for documenting E/M office level visits 2 through 5 and may choose one of the following three options: (1) existing framework of 1995 or 1997 E/M guidelines for history, physical exam, and medical decision making (MDM); (2) MDM only; or (3) physician time spent face-to-face with patients. Furthermore, CMS will consolidate payment rates for E/M office visits for levels 2-4 and retain a separate payment for level 5 visits. There will be three new add-on codes for primary care services, complex non-procedural specialty E/M visits, and extended visits. These new codes are expected to reflect the additional resources inherent in furnishing certain E/M services that are not accounted for in the valuation of base E/M codes. The new codes are not specialty-specific and are not expected to require an additional documentation burden.

7. **Reimbursement for Part B Drugs:** Medicare payment for existing drugs is generally tied to two factors, the Average Sales Price (ASP), which includes discounts and rebates, and the Wholesale Acquisition Cost (WAC). The ASP applies to drugs that are already on the market, not to new ones. To support the goal of reducing Medicare payment for new drugs, CMS is reducing the manufacturer's Wholesale Acquisition Cost (WAC) from 6% to 3%. There is no change to reimbursement for the Average Sales Price (ASP).

8. **Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services:** The AUC program requires ordering providers to consult a qualified decision support mechanism. The voluntary reporting period began in July 2018 and runs through December 2019. The program will begin in 2020 and will have an educational and operational testing period.

Changes to Quality Reporting

1. **Clinician Eligibility:** When MACRA passed in 2015, Eligible Clinician (EC) included physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse anesthetists. New categories for 2019 include physical and occupational therapists, clinical social workers, qualified speech-language pathologists, audiologists, registered dietitians/nutritional professionals, and clinical psychologists. The estimated number of new clinicians is 798,000.

2. **Low-Volume Exclusions:** CMS is adding an additional criterion for excluding low-volume clinicians from the MIPS program. As in 2018, ECs and groups that bill $90,000 or less in Medicare Part B charges, see 200 or fewer Medicare beneficiaries, or provide 200 or fewer covered professional services can apply for the low-volume opt-out. The criteria related to part B drugs no longer applies. A new **opt-in opportunity** for individuals or groups that exceed one or two of the three low volume criteria and that wish to apply to become eligible for a payment bonus or penalty.

3. **MIPS Scoring:** MIPS scoring will continue to be done on a scale from 0-100 based on data in four performance categories: Quality (45 points); Promoting Interoperability (previously called Advancing Care Information, 25 points); Cost (15 points, up from the previous 10); and Improvement Activities (15 points). ECs and group practices must now earn at least 30 points (up from the previous 15 requirement) in order to avoid a Medicare penalty of up to 7% in 2021. The Bipartisan Budget Act of 2018 changed the application of the MIPS payment adjustments, applying them only to professional services and not to Part B drugs.

4. **MIPS Reporting Period:** ECs and groups must report a minimum of 90 consecutive days of data for the Promoting Interoperability and Improvement Activities categories and 12 months of Quality measure data.

5. **MIPS Quality Reporting:** The 2019 rule adds 10 new MIPS Quality measures, removes 34, and maintains the 2018 rules for "topped out" measures. ECs and groups must still report at least six Quality measures, including one outcome or high priority measure, for at least 60% of applicable patient encounters and a minimum of 20 cases. CMS will continue to evaluate each measure against a benchmark to determine a score. With respect to the submission of Quality information, CMS will allow reporting of Quality measures using multiple data collection types, but not the CMS Web Interface. There are important changes relating to small practices or 15 or fewer ECs. Historically, only individual ECs could use claims-based reporting. CMS has expanded the option to include both individual ECs and small practices of 15 or fewer ECs.

6. **Certified EHR Technology (CEHRT) Requirements:** One of the more controversial components of the Final Rule applies to the required software used to submit data. 2015 CEHRT is now required even though only 66% of ECs had software that met the criterion during the first quarter of 2018. In recognition of the problem, CMS has added a hardship exception for ECs whose vendors will not be producing a 2015 Edition CEHRT version.

7. **MIPS Promoting Interoperability Reporting:** Formerly called Advancing Care Information, this category has a new name. Moving away from base, performance, and bonus scoring, CMS now uses performance-based scoring except for measures that require a yes/no response. ECs and groups must report from four objectives. The four scores will be added together to calculate the overall category score of up to 100 points. There is no longer a bonus for reporting certain improvement activities using CEHRT. Two new measures for the e-Prescribing objective, Query of Prescription Drug Monitoring and Verify Opioid Treatment Agreement, are optional in 2019 and 2020. The hardship exemption remains and applies to the new clinician types added in 2019.

8. **Facility-Based Measurement for ECs:** Starting in 2019, ECs who perform at least 75% of their services in the hospital inpatient, on-campus outpatient, or emergency department setting can meet a new Facility-Based standard. CMS will calculate the quality and cost scores for qualifying

ECs and groups using a hospital's performance in the Medicare Hospital Value-Based Purchasing program.

9. **Quality Reporting for Participants in Value-Based Arrangements with Medicare Advantage (MA) Plans:** In 2018, participants in value-based arrangements with Medicare Advantage plans (MAQI) could be required to comply with the requirements of both the MA plans and of MIPS. Recognizing the dual reporting burden, CMS now exempts from MIPS reporting requirements both ECs and group practices that are participating in the MA MAQI demonstration.

More Information About Medical Practice Management

For more information on medical practice management, contact us at **Margie@satinskyconsulting.com** or **919.383.5998** or visit our website at **www.satinskyconsulting.com**.

We provide services to start-up and established medical practices. These previous newsletters provide insight into just a few of the many issues with which we can assist.

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