



mln listening session

A MEDICARE LEARNING NETWORK® (MLN) EVENT

Physician Fee Schedule Proposed Rule: Understanding 3 Key Topics Listening Session

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Acronyms in this Presentation

- **APM** Alternative Payment Models
- **CEHRT** Certified Electronic Health Records Technology
- **CMS** Centers for Medicare & Medicaid Services
- **CPT** Current Procedural Technology
- **CY** Calendar Year
- **E/M** Evaluation and Management
- **ESRD** End Stage Renal Disease
- **FQHC** Federally Qualified Health Center
- **MLN** Medicare Learning Network
- **MIPS** Merit-based Incentive Payment System
- **PFS** Physician Fee Schedule
- **QP** Qualifying Alternative Payment Model Participant
- **QPP** Quality Payment Program
- **RHC** Rural Health Clinic
- **TIN** Tax Identification Number



Agenda

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Opening Remarks

Administrator Seema Verma



Patients Over Paperwork

- The [Patients Over Paperwork](#) initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients' ability to make decisions about their own care.
- Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
- This Administration has listened and is taking action.
- The proposed changes to the Physician Fee Schedule address those problems head-on, by proposing to streamline documentation requirements to focus on patient care and proposing to modernize payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.



When & Where to Submit Comments

- See the [proposed rule](#) for information on submitting formal comments by September 10, 2018.
- Proposed rule includes proposed changes not reviewed in this presentation so please refer to proposed rule for complete information
- Feedback during presentation not considered as formal comments; please submit comments in writing using formal process
- See [proposed rule](#) for information on submitting comments by close of 60-day comment period on September 10 (When commenting refer to file code CMS-1693-P)
- Instructions for submitting comments can be found in proposed rule; FAX transmissions will not be accepted
- You must officially submit your comments in one of following ways:
 - electronically through Regulations.gov
 - by regular mail
 - by express or overnight mail
 - by hand or courier



Documentation Requirements and Payment for Evaluation and Management (E/M) Visits

Emily Yoder



Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is required for physicians and others to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.
- **Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.**



Documenting E/M Requires Choosing the Appropriate Code

- **Currently, documentation requirements differ for each level and are based on either the 1995 or 1997 E/M documentation guidelines.**
- Billing Medicare for an Evaluation and Management (E/M) visit requires the selection of a Current Procedural Terminology (CPT) code that best represents:
 - Patient type (new v. established),
 - Setting of service (e.g. outpatient setting or inpatient setting), and
 - **Level of E/M service performed.**

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Level of E/M Visits

- The code sets to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code a practitioner may bill within the appropriate category.
- The three key components when selecting the appropriate level of E/M services provided are **history**, **examination**, and **medical decision making**. For visits that consist predominantly of counseling and/or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M services.



Proposed Payment for Office/Outpatient Based E/M Visits

- Proposing a single PFS payment rate for E/M visit levels 2-5 (physician and non-physician in office based/outpatient setting for new and established patients).
- Proposing a minimum documentation standard where, for Medicare PFS payment purposes for an office/outpatient based E/M visit, practitioners would only need to document the information to support a level 2 E/M visit (except when using time for documentation).



Why Change?

- Stakeholders have said that the 1995 and 1997 Documentation Guidelines for E/M visits are clinically outdated, particularly history and exam, and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care. Furthermore, the guidelines may not be reflective of changes in technology, or in particular, the way that electronic medical records have changed documentation and the patient's medical record.
- According to stakeholders, some aspects of required documentation are redundant
- Additionally, current documentation requirements may not account for changes in care delivery, such as a growing emphasis on team-based care, increases in the number of recognized chronic conditions, or increased emphasis on access to behavioral health care.



Medical Decision Making or Time

- We propose to allow practitioners to choose, as an alternative to the current framework specified under the 1995 or 1997 guidelines, either MDM or time as a basis to determine the appropriate level of E/M visit.
- This would allow different practitioners in different specialties to choose to document the factor(s) that matter most given the nature of their clinical practice.
- It would also reduce the impact Medicare may have on the standardized recording of history, exam and MDM data in medical records, since practitioners could choose to no longer document many aspects of an E/M visit that they currently document under the 1995 or 1997 guidelines for history, physical exam and MDM.



Proposed Payment for Office/Outpatient Based E/M Visits

Level	Current Payment* (established patient)	Proposed Payment**
1	\$22	\$24
2	\$45	\$93
3	\$74	
4	\$109	
5	\$148	

Level	Current Payment* (new patient)	Proposed Payment**
1	\$45	\$44
2	\$76	\$135
3	\$110	
4	\$167	
5	\$211	

* Current Payment for CY 2018

**Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate



Resource Use During a Visit

- We recognize that primary care services frequently involve substantial non-face-to-face work, and note that there is currently coding available to account for many of those resources, such as chronic care management (CCM), behavioral health integration (BHI), and prolonged non-face-to-face services.
- The currently available coding still does not adequately reflect the full range of primary care services, nor does it allow payment to fully capture the resource costs involved in furnishing a face-to-face primary care E/M visit.
- We are proposing to create a HCPCS G-code for primary care services, GPC1X(Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an established patient evaluation and management visit)).



Resource Use During a Visit

- We are also proposing to create a HCPCS G-code to be reported with an E/M service to describe the additional resource costs for specialty professionals for whom E/M visit codes make up a large percentage of their overall allowed charges and whose treatment approaches we believe are generally reported using the level 4 and level 5 E/M visit codes rather than procedural coding. Due to these factors, the proposed single payment rate for E/M levels 2 through 5 visit codes would not necessarily reflect the resource costs of those types of visits.
- Therefore, we are proposing to create a new HCPCS code GCG0X (Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit)).



Summary: How to Streamline E/M Payment and Reduce Clinician Burden

- Proposing to provide practitioners choice in documentation for office/outpatient based E/M visits for Medicare PFS payment: 1) 1995 or 1997 documentation guidelines, 2) medical decision-making or 3) time.
- Proposing to expand current policy regarding history and exam, to allow practitioners to focus their documentation on **what has changed** since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information.
- Proposing to allow practitioners to **review and verify** certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.
- Soliciting comment on how documentation guidelines for medical decision making might be changed in subsequent years.



Proposed Additional Payment Codes

- Proposing **~\$5 add-on payment** to recognize additional resources to address inherent complexity in E/M visits associated with primary care services.
- Proposing **~\$14 add-on payment** to recognize additional resources to address inherent visit complexity in E/M visits associated with certain non-procedural based care.
- Proposing a **multiple procedure payment adjustment** that would reduce the payment when an E/M visit is furnished in combination with a procedure on the same day.
- Proposing an **~\$67 add-on payment for a 30 minute prolonged E/M visit.**



Question & Answer Session #1

Documentation Requirements and Payment for Evaluation and Management (E/M) Visits



Advancing Virtual Care

Lindsey Baldwin



Advancing Virtual Care

- In response to the CY 2018 PFS Proposed Rule, we received feedback from stakeholders supportive of CMS expanding access to services that support technological developments in healthcare.
- We are interested in recognizing changes in healthcare practice that incorporate innovation and technology in managing patient care.
- We are aiming to increase access for Medicare beneficiaries to physicians' services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology.



Advancing Virtual Care

- To support access to care using communication technology, we are proposing to:
 - Pay clinicians for virtual check-ins – brief, non-face-to-face assessments via communication technology;
 - Pay Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit;
 - Pay clinicians for remote evaluation of patient-submitted photos or recorded video; and
 - Expand Medicare telehealth services to include prolonged preventive services.



Question & Answer Session #2

Advancing Virtual Care



Quality Payment Program

Molly MacHarris
Corey Henderson



Merit-based Incentive Payment System (MIPS) Proposals for Year 3 (2019)

MIPS Eligible Clinician Types:

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Register Nurse Anesthetists



Year 3 (2019) Proposed

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Clinical Social Workers



Merit-based Incentive Payment System (MIPS) Proposals for Year 3 (2019)

Low-Volume Threshold Determinations:

1. Continued compliance with the Bipartisan Budget Act of 2018.
 - The Year 3 (2019) low-volume threshold determinations will only be made on **covered professional services** under the **Physician Fee Schedule (PFS)**.
 - Different from the 2017 Transition Year where the low-volume threshold determinations were made on all Medicare Part B allowed charges.
2. **Proposing** to add a third element – Number of Services – to the low-volume threshold determination criteria.
 - The proposed criteria includes:
 - Dollar amount
 - Number of beneficiaries
 - Number of services (Newly proposed)
3. **Proposing** to add an opt-in option for clinicians who are excluded from MIPS.
 - This proposal gives clinicians who would have been excluded in previous years the choice to participate in MIPS. 26



Merit-based Incentive Payment System (MIPS) Proposals for Year 3 (2019)

Performance Category Weights:

Performance Category	Performance Category Weights		
	Year 1 (2017)	Year 2 (2018)	Year 3 (2019) – Proposed
 Quality	60%	50%	45%
 Cost	0%	10%	15%
 Improvement Activities	15%	15%	15%
 Promoting Interoperability	25%	25%	25%



Merit-based Incentive Payment System (MIPS) Proposals for Year 3 (2019)

Performance Categories – Additional High-Level Proposed Changes:

- **Quality:** Remove certain measures as a part of the Meaningful Measures Initiative and shift the small practice bonus from the final score calculation into this performance category.
- **Cost:** Add 8 new episode measures.
- **Facility-based quality and cost measures:** Expand the number of clinicians who can be measured in MIPS based on the reporting they do at their hospital.
- **Improvement Activities:** Additional refinements to the Improvement Activities inventory.
- **Promoting Interoperability:** Overhaul the category to align clinician policies with hospital policies, reduce measures, and change scoring to be focused on performance.



Merit-based Incentive Payment System (MIPS) Proposals for Year 3 (2019)

Performance Threshold and Payment Adjustment:

Performance Period	Performance Threshold	Exceptional Performance Bonus	Payment Adjustment*
Year 1 (2017)	3 points	70 points	Up to +4%
Year 2 (2018)	15 points	70 points	Up to +5%
Year 3 (2019) - Proposed	30 points	80 points	Up to +7%

*Payment adjustment (and exceptional performer bonus) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance. To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a “scaling factor.” The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.



Merit-based Incentive Payment System (MIPS) Proposals for Year 3 (2019)

Seeking Comment:

Policy Items	Seeking Comment under Proposed Rule
Expansion of Facility-based Measurement	To determine MIPS Cost and Quality scores based on performance for clinicians in ESRD and post-acute care settings.
Future Approaches to Scoring the Quality Performance Category	To simplify the MIPS Quality performance category by assigning different values to different measures and measurement sets.
Subgroup Reporting	To determine different approaches for subgroups to participate in MIPS.
Cross-Performance Category Measurement Sets	To include measure sets that span multiple performance categories.



Advanced Alternative Payment Models (APMs) Proposals for Year 3 (2019)

General:

- Updating the Advanced APM CEHRT threshold so that an Advanced APM must require that at least 75 percent of eligible clinicians in each APM Entity use CEHRT.
- Extending the 8% revenue-based nominal amount standard for Advanced APMs through performance year 2024.

MIPS APMs and the APM Scoring Standard:

- Clarifying the requirement for MIPS APMs to assess performance on quality measures and cost/utilization.
- Updating the MIPS APM measure sets that apply for purposes of the APM scoring standard.



Advanced Alternative Payment Models (APMs) Proposals for Year 3 (2019)

All-Payer Combination Option:

- Increasing flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program.
 - Establishing a multi-year determination process where payers and eligible clinicians can provide information on the length of the agreement as part of their initial Other Payer Advanced APM submission, and have any resulting determination be effective for the duration of the agreement.
 - Allowing QP determinations at the TIN level, in addition to the current options for determinations at the APM entity level and the individual level, in instances when all clinicians who bill under the TIN participate as a single APM Entity.
 - Moving forward with allowing all payer types to be included in the 2019 Payer Initiated Other Payer Advanced APM determination process for the 2020 QP Performance Period.
- Streamlining the definition of a MIPS comparable measure in both the Advanced APM criteria and Other Payer Advanced APM criteria.



Question & Answer Session #3

Quality Payment Program



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