

Centers for Medicare & Medicaid Services
Physician Nurses & Allied Health
Open Door Forum
Moderator: Jill Darling
February 20, 2018
2:00 p.m. ET

Operator: Good afternoon. My name is (Amy) and I will be your conference facilitator today. At this time, I would like to welcome everyone to the Centers for Medicare & Medicaid Services Physician Nurses & Allied Health Open Door Forum.

All lines have been placed on mute to prevent any background noise. After the speakers' remarks, there will be a question and answer session. If you would like to ask a question during this time, please press star then the number one on your telephone keypad. If you would like to withdraw your question, you may press the pound key.

I would now like to turn the call over to Jill Darling. You may begin.

Jill Darling: Thank you, (Amy). Good morning and good afternoon, everyone and welcome to today's Physicians Open Door Forum.

Before we get into today's short agenda, I have one brief announcement. This open door forum is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in but please refrain from asking questions during the Q&A portion of the call. If you do have any inquiries, please contact as at press@cms.hhs.gov.

So up next, excuse me, first off, we have Marge Watchorn, one of our co-chairs who will go over the Bipartisan Budget Act of 2018 so that a brief overview of the Medicare extender provision.

Marge Watchorn: Thank you, Jill. Hi, everybody and thank you so much for joining us on today's call. I'm sure you may have heard that the Bipartisan Budget Act was enacted on Friday, February 9th.

I wanted to give you all a brief overview of some of the provisions that we think are going to be most interesting for you all and just wanted to say that, you know, that the works that the agency is doing to implement these provisions. It's going to be ongoing for a while. And obviously, since the legislation was just enacted a couple of weeks ago, we don't have a lot of detail yet for you in terms of how we're going to implement and operationalize all these provisions. But I wanted to kind of layout there for you a brief summary of what the provisions entail.

So the first, provision is Section 50202 and this repeals the caps on outpatient therapy. It repeals those caps effective January 1, 2018, so that has a retroactive effect of date. It replaces the caps with payment restrictions to ensure appropriate therapy. It does this in a couple of different ways.

First, it requires that providers use a modifier, specifically the KX modifier on claims over the amount specified in Medicare law in order to attest that those therapy services are medically necessary. And those amounts, which are specified, are \$2,010 per occupational therapy and then a combined amount of \$2,010 per physical therapy and speech language therapy.

It also establishes a lower threshold amount of \$3,000, which is in effect for calendar years 2018 through 2027 at which certain therapy services would be subject to a targeted medical review. Beyond 2027 or 2028 and for later years that threshold amount would be increase by the Medicare Economic Index or the MEI.

The next provision is Section 50302, which is an expansion of the Medicare telehealth service, specifically for home dialysis services. That provision goes into effect January 1, 2019, so that's coming up in, you know, CMS as well that's actually coming up pretty soon.

So, definitely be looking for guidance from the agency on that, potentially through rule-making in the future and we'll certainly share more details with you all and we have them on our plans for implementing that expansion of the telehealth.

There's also an expansion of telehealth for stroke services, which goes into effect January 1, 2021, so a couple more years to implement that. But, again, look for potential rule-making regarding that expansion of telehealth. And – sorry, that's Section 50325.

The next section is 51009 which essentially it's a little bit complicated, it freezes the radiation therapy payments under the Physician Fee Schedule at the rates that were set in 2016. It continues that freeze for calendar year 2019. That was set to expire. The freeze would set to expire in 2018. This provision would extend that freeze for an additional year for calendar year 2019.

Next, Section 53106 lowers the update – the annual update to the conversion factor that we used to calculate rates under the Medicare physician fee schedule, lowers the update amount for calendar year (29). Lowers it from 0.50 percent to 0.25 percent.

And then finally, the last provision I just wanted to touch on was Section 53107 which makes several changes for occupational therapy and physical therapy services, which are furnished and provided by a therapy assistant. It requires the agency to establish a modifier, and that provision goes into – would be come effective January 1 of 2019 so that's, you know, start of next year. Look for us to be acting on that pretty quickly. Also this section also requires claim for services provided by a therapy assistant to include that modifier effective January 1, 2020, so the following year.

And then two years after that, it establishes a payment for such services, again, provided by a therapy assistant at a reduced amount of 85 percent of the Medicare fees schedule amount and that goes into effect January 1, 2022. So it's kind of ruling implementation before that section would be fully implemented. So we'd be looking for more information from the agency on that.

And, Jill, that's all I have.

Jill Darling: All right. Thank you, Marge. And up next and last we have Felicia Lane, who has some reminders about Open Payments Program Year 2017.

Felicia Lane: Thank you, Jill. I'm Felicia Lane from Center for Program Integrity, Data Sharing and Partnership Group in the Division of Data and Informatics.

As a reminder for those of you who are unfamiliar with Open Payments, it is a national transparency program which requires the transfer of values by drug, device, biological and medical supply manufacturers to physicians and teaching hospitals be published on a public website.

In June of 2017, CMS published 11.96 million records that attributable to 630,824 physicians and 1,146 teaching hospitals. These financial transactions totaled \$ 8.18 billion of transfers of value from healthcare industry to healthcare providers.

The Open Payments data is refreshed once annually following its initial publication. On January 17th of this year, CMS updated our Open Payments dataset to reflect the changes to the data that took place since June 30th, 2017. The refresh included changes to records, changes to delay in publication flags, changes to disputed records, adjustments for records that were deleted since the previous publication.

Applicable manufacturers and our group purchasing organizations are currently submitting for Program Year 2017 data submission. Submission ends March 31st.

As a reminder, physicians and teaching hospitals can register in the Open Payments system so that you may be able to review and affirm records that are attributed to them and if necessarily dispute those records.

In order to participate in the upcoming review and dispute period, physicians and teaching hospitals must be registered in our Open Payments system. If

you are new to the Open Payments system you would need to register via our CMS Enterprise Identity Management system (EIDM).

And for those of you who are new or even who want to just refresh your memory about Open Payments, please visit our website at www.cms.gov/openpayments. Click on the "About" tab and under at the bottom you'll see "Resources" tab, you'll be able to find step by step instructions on how to register in Open Payments EIDM system. Also you will find the quick reference guide and tutorials on how to access and navigate through the system.

Our review on dispute period is set to begin on April 1st but we encourage early registration and preparation for the period so that you are all set to participate in our review and dispute period when it opens up.

If you have previously register in the Open Payments system but have not access your account in 180 days, you would need to reactivate your account. Reactivation can be completed through our Open Payment help desk. You can call our help desk at 1-855-326-8366 and our help desk is available to answer questions from 8:30 a.m. to 7:30 p.m. EST

Also, we are hosting on March 14th from 2:00 to 3:00 p.m. EST, our Open Payment National Provider call where we'll provide an overview of the Open Payments program. We will also discuss the program timelines and we'll talk about critical deadlines for physicians and teaching hospitals to review and dispute the data. We encourage you to attend and please feel free to share this information to others.

That's all I had, Jill. I will turn it back over to you. Thank you.

Jill Darling: Thank you, Felicia, and thank you to Marge. (Amy), we'll open the line for Q&A, please.

Operator: As a reminder, ladies and gentlemen, if you would like to ask a question, please go ahead and press star then the number one on your telephone keypad. If you would like to withdraw your question, you may use the pound key.

Please limit your questions to one questions and follow-up to allow other participants' time for questions. If you require any further follow-up, you may again press star one to rejoin the queue.

Your first question today comes from the line of (Betsy Nicoletti) of MPC.
Your line is open.

(Betsy Nicoletti): Thank you. I understand that the GPCI floor was reinstated and that it was going to be retroactive to the first of the year. What's going to happen for those payments in the localities that were less than one? Are they going to be adjusted upwards or how and when is that going to happen?

Marge Watchorn: Since ...

Jill Darling: Hi.

Marge Watchorn: I think this one might be for me. Thanks – this is Marge Watchorn. Thank you so much for the question and you pointed out that inadvertently neglected to include the change to the work GPCI floor. As you correctly noted, that provision went into effect January 1, 2018, our plan is to – and I believe the files have already been released. Our plan is to release correct set of files with the payment amounts. And for those files, rather for those new payment rates, the correct payment rates in accordance with the law to be retroactively effective to January 1, 2018.

(Louisa Rink): Hi, Marge. This is (Louisa Rink) from PBG.

Marge Watchorn: Yes.

(Louisa Rink): I just wanted to clarify. Yes, the new file was the updated floor for the GPCIs have been released so providers should start seeing their claims paid with that updated information. Claims that were paid prior to the passage of the act will be reprocessed. We do not yet have a timeframe for that reprocessing, but they will all be reprocessed and we do not believe there will be need for provider intervention.

(Betsy Nicoletti): Thank you so much.

Marge Watchorn: Yes. Thank you very much, (Louisa). That's helpful.

Operator: And again, ladies and gentlemen, if you would like to ask a question, please go ahead and press star then the number one on your telephone keypad.

And your next question, (Betsy Nicoletti), your line is open once again.

(Betsy Nicoletti): I'm sorry. I'm having all the air time. My next question is about MIPS and whether the cost category is going to stay at 10 percent of the performance score or not for 2019. So, is it going to stay at 10 percent for the next few years or go up in 2019 to 30 percent? I wonder if anybody knows that offhand.

Marge Watchorn: This is Marge. I don't have the answer to that question. Does anyone else, any of the other speakers know?

Felicia Lane: Marge, this is Felicia. I'm not certain we've got the right folks on the call to answer that. I think that's probably CCSQ question.

Marge Watchorn: Got you.

Operator: And you have a question ...

Marge Watchorn: Would it be possible – I'm sorry. Excuse me, (Amy). Would it be possible to e-mail that question to us so we can correctly route it to the right folks here at CMS?

(Betsy Nicoletti): Yes, I'll do that. Thank you very much.

Marge Watchorn: Sure, thank you.

Operator: And your next question comes from the line of (Gail Brochias). Your line is open.

(Gail Brochias): Thank you. And, again, I'm not sure if the proper people are on the line to answer this question. Is there any one on the line that can answer a survey – Department of Health survey-related question?

Louisa Rink: Can you tell us a little bit more about the nature of the survey?

(Gail Brochias): It's something new that we've all heard about and that's in the past if an employee violated facility policy and there was documented evidence that training had occurred and the employees violated facility policy. If there were a Department of Health citation, there would not be a citation against the facility, the employee might be affected. Now, we're being told that even if it's a clear violation of policy by an employee that has been properly trained that the facility also will receive a citation. Is that correct?

Marge Watchorn: Again, this is Marge. That doesn't ring any bells with me. It maybe helpful, again, and I apologize I don't – maybe we have the right folks on the line. Does any else, any of the other speakers have any thoughts on this one?

(Louisa Rink Marge, it's (Louisa). I think that this might actually be a State Department of Health issue. I'm not certain that we would be positioned to best answer it.

(Gail Brochias): OK, thank you.

Marge Watchorn: But I have the same hunch, (Louisa) that you do, but that said, if you'd like, please feel free to e-mail that question to us and, you know, maybe with a little more time to think about it we can help direct you to the right folks.

(Gail Brochias): Thank you.

Marge Watchorn: Sure.

Operator: And your next question comes from the line of Carl Langhoff of Marshfield Clinic. Your line is open.

Carl Langhoff: Good afternoon. I was just curious if there is – if or when there'll be some CMS correspondence in regards to the fix to the therapy cap. Our PT departments have been asking a lot of questions and we've been kind of waiting for that official guidance.

Marge Watchorn: The short answer is yes. This is a very – it's a fairly complex provision and that on its (face) repeals the therapy caps but then lives in place a limitation that frankly we haven't quite decided yet what we're going to call it because it sure looks and acts a lot like the now repealed therapy caps. So we ...

Carl Langhoff: Right. And that's actually what our PT has been saying. And unfortunately, all of their societies are really just sending blast of information and we're just waiting for something official.

Marge Watchorn: Yes. We are working ...

(Louisa Rink): And also ...

Marge Watchorn: ... official guidance. And (Louisa), you may have some thoughts on this as well.

(Louisa Rink): Yes, I mean, I want to echo Marge's statement that although the cap is repealed, the statute, which you may have read sort of also leaves it in place. For the time being as far as claims processing is concerned, if you continue to follow the rules that were in place prior sending in the KX modifier when you hit the cap as you did last year, then your claims will process as it would have before. And we are working hard to try to understand both the policy and the operational implications of this passage. And we will be coming out with formal guidance but we're just not there quite yet.

Operator: And your next question comes from the line of Ed Gaines of Zotec Partners. Your line is open.

Ed Gaines: Thank you. In the final rule published in November for 2018, CMS said that they were going to reevaluate the documentation guidelines for physician services. I was wondering if anyone could comment where the agency is in that process, where you are in terms of the timeline. Can you give us any idea when and if you'll be issuing guidance in that area or seeking inputs from stakeholders? Thank you.

Marge Watchorn: Sure. This is Marge Watchorn. I can speak to that one. It's a great question. And it's definitely the intention, the stated intention in the final rule of the agency to continue to look at simplifying documentation requirement, so you may be aware of that the agency recently implemented through sub-regulatory mean change in the way teaching and physician, verify information documented in the patient records by medical student. And that guidance as I understand it has been quite well received by the stakeholder community.

That said, any other action that we might take regarding other documentation rules to the extent that those rules are have been implemented though rule-making I think that you could certainly look to the proposed rule, which is generally published around July 1 of each year, excuse me, the proposed physician fee schedule rule to see what other proposals we might include for 2019? So that's a great question and it's something that we've been doing a lot of thinking about here at the agency.

Ed Gaines: Thank you.

Marge Watchorn: Sure.

Operator: Your next question comes from the line of Marilyn Ender Blume of Covenant Hand. Your line is open.

Marilyn Ender Blume: Thank you. As far as you know on therapy, on the \$3,000 amount for subject to medical review, is that medical review post payment or would they hold the claims until they do the review?

(Louisa Rink): This is (Louisa Rink). The medical review should function in the same fashion in which it functions today. It's just that the thresholds have changed a little bit.

So today, I think – and I'm sorry, I don't have it in front me, I think it's \$3,700 threshold and they're moving it to \$3000, but it'll function exactly the way it does today, at least for the time being.

Marilyn Ender Blume: OK. Thank you.

Marge Watchorn: Also thank you, (Louisa). I think that's absolutely right. The folks at CMS who actually implement all of the medical review requirements are with the center for program integrity and I'm not sure if we have those folks on the line today who could speak more to sort of what the process would entail.

Operator: And again, ladies and gentlemen, if you would like to ask a question, please go ahead and press star then one on your telephone keypad.

And there are no further questions in queue at this time. Sorry, we do have another question from the line of (Sharon de Senti). Your line is open.

(Sharon de Senti): Hi, good afternoon. I was just wondering if there will be something in print where you review those sections. That was very helpful, but I didn't quite get all down. Is there a way that we can get an overview of that?

Marge Watchorn: That's a great question. I'm sorry ...

(Louisa Rink): This is (Louisa). If go to appropriations.senate.gov, you'll find both the text of the bill and the summary of the bill that Appropriation Committee put out.

(Sharon de Senti): [Appropriations.senate.gov](https://appropriations.senate.gov)?

(Louisa Rink): That's correct.

(Sharon de Senti): Thank you.

Marge Watchorn: Yes.

Operator: And there are no further questions in queue at this time. I turn the call back over to the presenters.

Jill Darling: All right. Well, thank you everyone for your questions today and to Felicia and to Marge. So we hope to see you in the next six week or so for the next Physician's Open Door Forum. Thanks, everyone. Have a great day.

Operator: Thank you for participating in today's Physician Nurses & Allied Health Open Door Forum conference call. This call will be available for replay beginning

today at 5:00 p.m. Eastern through midnight on February 23rd. The conference I.D. number for the replay is 31620501. The number to dial for the replay is 855-859-2056.

This concludes today's conference call. You may now disconnect.

END