

Centers for Medicare and Medicaid Services
Physicians
Open Door Forum
Moderator: Jill Darling
Thursday, July 19, 2018
2:00 PM ET

Coordinator: Good morning or good afternoon everyone and thank you all for holding. Your lines have been placed on a listen-only mode until the question and answer portion of today's conference. During the question and answer session, you can press Star then 1 on your touch tone phone to ask any questions. Please be sure your phone line is unmuted and state your name at the prompt so we can announce your name prior to you asking your question.

Today's call is being recorded. If you have any objections please disconnect at this time. I'd like to turn our call over to our first speaker today, Miss Jill Darling. Ma'am, you may begin.

Jill Darling: Thanks, (Kevin). Good morning and good afternoon everyone, I'm Jill Darling in the CMS Office of Communications, and welcome to today's Physicians Open Door Forum. We have a pretty jam-packed agenda and we do appreciate you waiting and, you know, recording all your information since there were a number of folks joining today. After my brief announcement we'll get right into our agenda.

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 and A portion. If you have any inquiries, please contact CMS at Press@cms.hhs.gov, and now I'll hand the call off to Marge Watchorn.

Marge Watchorn: Thank you Jill and thank you to everybody who took the time out of their day to participate in the Open Door Forum today. We're hoping to be able to provide for you an overview of all of the more high-profile and important proposals that we included in the physician fee schedule rule. There are many other proposals that we may not have time to go into today, so as with all of our proposed rules, we encourage you to review the proposals and for those of you who would choose to submit comments to us, definitely encourage you to follow the formal written process that's described in the front of the proposed rule.

And as a reminder, public comments on this rule are due on Monday, September 10, and the rule is scheduled for formal publication in the Federal Register a week from tomorrow on Friday, July 27, so at that point you can download the official version and have all the proper citations.

So as you are aware, a week ago on July 12 we issued a proposed rule for the physician fee schedule, which includes a number of payment policies, updates to payment rates as well as quality provisions for services furnished on or after July 1, 2019. I will be sharing with you the highlights of two of those topics included in the PFS rules, specifically around evaluation and management services as well as some exciting proposals regarding communication-based technology services and tele-health.

So starting with evaluation and management payment, as well as reducing clinician burden, just so you know, for those who may not be familiar with the terminology, I'm not going to say evaluation and management, I'm going to use the colloquial E&M.

So we are proposing a number of changes to the way we pay for E&M visits under the Medicare Physician Fee Schedule. Specifically we are allowing, proposing to allow practitioners to choose the document, the office and outpatient E&M visits using either medical decision-making or time as the basis for which visit level they choose, instead of applying the current E&M documentation guidelines that are posted on the CMS web page and that were issued back in 1995 as well as a set of documentation guidelines that were issued in 1997.

We're also proposing to expand the current options by allowing practitioners to use time as the governing factor in selecting the visit level as well as in documenting the E&M visit regardless of whether counseling or care coordination are the dominant elements within that E&M visit.

We are also proposing to expand the current options regarding documentation of the history and exam elements of an E&M visit. The goal is to allow the practitioners to focus their documentation on specifically what has changed for the patient since the last visit or any other pertinent items that may not have changed as opposed to what they may be currently doing under the rules, which could be re-documenting information that already exists in the record as long as they review and update any previous information.

We're also proposing to allow practitioners to simply review or verify certain information in the medical record that may have already been entered by ancillary staff or by the beneficiary rather than requiring the practitioner, the billing practitioner to re-enter that information into the medical record. We're also soliciting comment on how the documentation guidelines for medical decision-making could be changed in subsequent years.

So that's regarding documentation. Also, regarding payment for E&M office outpatient visits, levels two through five, in an effort to improve both payment accuracy as well as simplify the documentation requirements, we propose new single-blended payment rates for new patients as well as for established patients, as well as a series of add-on codes that would reflect the resources involved in furnishing both primary care as well as non-procedural specialty services.

As a corollary to this payment proposal, we're also proposing to apply a minimum documentation standard, where Medicare would require that the medical record include information to support only a level two CPT code visit for the history, the exam, and/or the medical decision-making in cases where the practitioners would choose to use the current framework or as proposed if they choose to use medical decision making to document E&M level two through five visits.

And then in cases where the practitioners would choose to use time to document their E&M office visits, we would propose that they would document the medical necessity of the visit and show the amount of time spent by the billing practitioner in face-to-face time with the patient. And also we would only require documentation to support the medical necessity of the visit, associated currently with the level two CPT visit code.

Other payment refinements that we're proposing to recognize efficiencies that are realized when E&M visits are furnished in conjunction with other procedures. We're proposing a multiple procedure payment adjustment that would apply in those circumstances. We're also proposing new coding to recognize podiatry E&M visits that would more specifically identify and value these services.

We're also proposing a new, prolonged face-to-face E&M code as well as a technical modification to the practice expense methodology. We're also soliciting public comment on the implementation time frame of these proposals. We recognize that these proposals have the potential to impact sort of across the spectrum of physicians who currently bill Medicare under the physician fee schedule, so we're open to comments about the right timeframe for implementing all of these proposals as well as how we might update the E&M visit coding and documentation in other care settings, settings other than the outpatient and office setting for future years.

Our belief is that these proposals would allow practitioners greater flexibility to exercise their own clinical judgment in documenting E&M visits so that they can focus on what is clinically relevant and medically necessary for the beneficiary.

And then moving on to some proposals that we have regarding communication-based technology services as well as tele-health. We're proposing for CY2019 to pay separately for two newly defined physician services, which are furnished using communication technology.

The first is what we're calling brief communication technology-based services, also known as a virtual check-in. We have a HCPCS code that we've developed for that. The second service is a remote evaluation of recorded video or images submitted by the patient, and we have a new HCPCS code for that as well.

And the way this would work is that patients could, I'm sorry practitioners could be separately paid for the brief communication technology-based service when they check in with beneficiaries via telephone or another type of tele-communications device in order to decide whether an office visit or

another type of service would be needed for that patient. And again, our belief is that this type paying for this type service would increase efficiency for practitioners as well as convenience for beneficiaries.

Similarly the remote evaluation of recorded video or images submitted by the patient would allow practitioners to be paid separately for reviewing patient submitted photo or video information, which would be transmitted and conducted via pre-recorded store and forward video or image technology. Again, with the effort of assessing whether or not a visit is needed.

We're also proposing next year to pay separately for a new codes to describe chronic care remote physiologic monitoring as well as several codes to describe inter-professional Internet consultation.

And finally, before I pass it off to some of my other colleagues, I wanted to share briefly about the sort of traditional Medicare tele-health service proposals that we have. We're proposing to add one code, two codes to the list of Medicare tele-health services, and those are two HCPCS codes that describe prolonged preventive services.

We're also proposing to implement the requirements of the Bipartisan Budget Act of 2018 for tele-health services related to beneficiaries with end stage renal disease who receive home dialysis as well as tele-health services for beneficiaries with acute stroke, both of those provisions are effective by law on January 1, 2019. So we're proposing a number of amendments to our current regulations governing Medicare tele-health in order to implement these proposals effective Jan 1, 2019.

Next I wanted to turn it over to my colleagues who work on the quality payment program for updates on their part of the role.

Aucha Prachanronarong: Thanks Marge, this is Aucha Prachanronarong from Centers for Clinical Standards and Quality, and I'll be speaking to the Merit-based Incentive Payment System or MIPS. For the first two years of the MIPS program we implemented policies that were designed to ease clinicians' transition into the program, and with the enactment of the Bipartisan Budget Act of 2018, we have been given additional authority to continue the scheduled transition for three more years.

We implemented some provisions of the Bipartisan Budget Act by changing the way that we calculated low-volume threshold for the 2018 MIPS performance period. This proposed rule includes some proposals that are directly related to the bipartisan budget act.

First, we are proposing to change how we apply the MIPS payment adjustment. So that adjustments will not apply to all services under Medicare Part B but rather would apply only to covered professional services paid under or based on physician fee schedule, and this change would start with the 2019 MIPS payment adjustment.

Second, we are also providing flexibility, or we were provided flexibility in the weighting of the cost performance category as a result of the Bipartisan Budget Act, and rather than weighting the cost performance category at 30%, which is what we were originally required to do for year three of the program, we are proposing to weight the cost performance category at 15% for year three. And we are also proposing to introduce eight episode-based cost measures under the MIPS cost performance category. This would be in addition to the Medicare spending for beneficiary measure and the total per capita cost measure.

And then the other major proposal that is related to the Bipartisan Budget Act is previously MACRA required for year three that we set the MIPS performance threshold at the mean or median of MIPS final scores, with the Bipartisan Budget Act we have additional flexibility for years three, four and five.

So for the 2019 MIPS performance period we're proposing to set the MIPS performance threshold at 30 points. Some other proposals related to MIPS that I'd like to highlight are, we are proposing to expand the definition of an MIPS-eligible clinician to include new clinician types, specifically we're proposing to include physical therapists, occupational therapists, clinical social workers and clinical psychologists in the definition of a MIPS-eligible clinician.

We are also proposing to add a third element to the low-volume threshold determination for the 2019 performance period so that to be excluded for MIPS, clinicians or groups would need to meet one of three criteria. Either having \$90,000 or less in covered professional services, providing care for 200 or fewer beneficiaries or providing 200 or fewer professional services under the physician fee schedule.

And along with the change in the low volume threshold, we are proposing to have an opt-in policy whereby clinicians who meet one or two elements of the low volume threshold but not all three would have the choice to participate in MIPS and be scored and subject to payment adjustments based on their MIPS final score.

With respect to the quality performance category, we're proposing to remove 34 quality measures and to replace them with 10 new MIPS quality measures. These include four patient-reported outcome measures, seven high-priority

measures and one measure that replaces an existing measure. And then we are lastly proposing to restructure the promoting interoperability performance category or what was formerly known as the advancing care information performance category. And I will turn it over to my colleague Ashley Hain to speak more to those.

Ashley Hain: Thank you, Aucha. Our proposal for the promoting inter-operability performance category, formerly known as advancing care information performance category, it's designed to focus on inter-operability health information exchange and providing patients access to their health information.

The proposed rule reiterates that clinicians are required to use the 2015 edition cert in 2019. We finalized this requirement in the 2018 quality payment program final rule.

We are proposing to align with the Medicare promoting inter-operability program, formerly called the EHR incentive program for eligible hospitals, and eligible critical access hospitals. We are proposing to retain the performance-based scoring and to eliminate the base performance and bonus scoring structure.

We are proposing to make the security risk analysis measure required but this measure will not be scored under the new scoring structure proposal. We are reducing the number of scored objectives from six to four objectives. We are also proposing to eliminate several measures, combine some measures and rename several measures.

We are also proposing three new measures for this performance category. We are proposing that all measures are required with the exception of the two new

measures. If reported, they will earn bonus points. For the public health and clinical data exchange objective, we are proposing to require two measures that are submitted for this objective. There are some exclusions to these required measures. If the exclusions are claimed, their points will be reallocated to the other measures.

So this summarizes our main proposals for the promoting inter-operability performance category, and now I'd like to hand it over to my colleagues for the advanced APM, Corey Henderson.

Corey Henderson: Good afternoon, everyone. At a high level, just wanted to kind of touch on two key things that we're doing this year. First of all we want to just let you know that we're continuing to support a pathway to participating and alternative payment models and advanced APMs. And our year three proposals are a reflection of that effort.

Our proposals for the advanced APM side of the program build off many of the policies that we finalized for year two, while we continue increasing flexibility and reducing burden. Specifically for advanced APMs we're proposing some adjustments to the advance APM criteria. We're updating the advance APM cert threshold so that advanced APMs must require that at least 75% of eligible clinicians in each APM entity use of cert.

We're proposing that we extend the 8% revenue-based nominal amount standard for advanced APMs through performance year 2024. For all payer combination option and other advanced APMs and other payer advanced APMs, we're proposing that for cert use, we increase the cert use criterion threshold for other peer advanced APMs, so that in order to qualify as another payer advance APM as of January 1, 2020, the number of eligible clinicians participating in the other payer arrangement who are using cert must be 75%.

In addition, we're proposing for the revenue-based nominal amount standard that we maintain the revenue based nominal amount standard for other payer advanced APMs at 8% through performance period 2024. We also propose an increasing flexibility for the all payer combination option and other payer advance APMs for non-Medicaid payers to participate in the quality payment program that we're 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 advance APM submission, and have any resulting determination be effective for the determination of the agreement.

We propose this streamline process to reduce the burdens on payers and also on the eligible clinicians. We propose allowing QP determinations at the ten 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 ten, participate as a single APM entity. This will provide additional flexibility for eligible clinicians under the all-payer combination option.

Moving forward, this will allow all-payer types to be included in the 2019 payer initiated other payer advance APM determination process for the 2020 QP performance periods.

Streamline the definition of a MIPS-comparable measure in both the advanced APM criteria and other payer advanced APM criteria to reduce confusion and burden among payers and eligible clinicians submitting payment arrangement information to CMS. Under the MIPS APM and APM scoring standard, we're proposing clarifying the requirement for MIPS APMs to assess performance on quality measures on cost utilization.

In other words, we're re-ordering the wording of this criteria to state that the APM basis payment on quality measures and cost utilization, which would clarify that the cost utilization part of the policy is broader than specifically requiring the use of a cost utilization measure.

We're proposing updating the MIPS APM measure sets that apply for purposes of the APM scoring standard. We're also proposing that we align PI reporting requirements under the APM scoring standard so that MIPS-eligible clinicians and any MIPS APMs, including the shared savings program, can report PI in any manner permissible under MIPS, at either the individual or group level, and PI is promoting inter-operability.

We will continue working with stakeholders to understand the needs of clinicians and practices and identify where new models are desired. At this time, I will hand things over Laurie McWright.

Laurie McWright: Thank you, Corey. As a part of the proposed rule, CMS also announced details for the proposed implementation of the Medicare advantage qualifying payment arrangement incentive demonstration, otherwise known as the MAQ demonstration.

It will allow participating clinicians to have the opportunity to be eligible for waivers that will exempt them from the MIPS reporting requirements and payment adjustments for a given year if they participate to a sufficient degree in qualifying payment arrangements with Medicare Advantage organizations during the performance period for that year, without requiring them to be a qualifying APM participant, i.e. QP or a partial QP or otherwise meet MIPS exclusion criteria.

Under this demonstration, clinicians are not required to have a minimum amount of participation in an advanced APM with Medicare fee-for-service in order to be exempt from the MIPS reporting requirements and payment adjustments for a year. The demonstration will not grant QP status to participating clinicians. Participating clinicians would still have to meet the threshold for participation under the Medicare option or all-payer combination option in order to become QPs and earn the incentive payment.

Additional information can be found on the Innovation at CMI, Innovation Center website. At this time, I will turn it over to (Sarah Shirey-Losso), who will discuss a proposal about Part B drugs.

(Sarah Shirey-Losso): Thank you Laurie. So I have two proposals to quickly discuss. The first is we are proposing that effective January 1, 2019 wholesale acquisition cost or WAC-based payments for new Part B drugs during the period where the first quarter of sales when the average sales price or ASP is unavailable. The drug payment add-on would be 3% in place of the 6% add-on that is currently being used. If this proposal is finalized, we would also update manual provisions in our Internet-only manual for sub-regulatory guidance, in order to permit the Medicare Administrative Contractors to use an add-on percentage of up to 3% rather than 6% when utilizing WAC for the pricing of new drugs.

I will also quickly touch on a proposal we're making regarding the clinical laboratory fee schedule. Beginning January 1, 2018, the payment amount for tests on the clinical lab fee schedule is generally equal to the weighted median of private payer rates determined for the test based on the data of applicable laboratories that is collected during the specified data collection period and then reported to CMS during a specified reporting period.

In determining payment rates under the private payer-based, rate-based clinical lab fee schedule, one of our objectives is to obtain as much applicable information as possible from the broadest possible representation of the national laboratory market on which to base the clinical lab schedule payment amounts without imposing undue burden on those entities.

In the interest of facilitating this goal, we are proposing a change to change the way Medicare Advantage payments are treated in our definition of applicable laboratory. If we were to finalize the proposed change, additional laboratories of all types serving a significant population of beneficiaries enrolled in Medicare Part C could meet the majority of Medicare revenue threshold and potentially qualify as an applicable laboratory and report data to CMS.

In addition, we're seeking public comments on alternative approaches for defining an applicable laboratory. For example, using a type of bill, 14X or using the CLIA certificate to define an applicable laboratory. We're also seeking public comments on potential changes to the low expenditure threshold component of the definition of applicable laboratory.

We're particularly interested in receiving comments from the physician community and small, independent laboratories as to the administrative burden and relief associated with revisions to the low expenditure threshold. And now I'll pass it back to Marge.

Marge Watchorn: Thank you, Sarah. Next I wanted to share with you a couple of proposals that we have in the physician fee schedule this year regarding burden reduction. You may recall that last year in the physician fee schedule proposed rule we included a broad request for information or RFI on ways that we could consider how to reduce the burden on physicians, practitioners, and other

clinicians, and as a result of reviewing the feedback that stakeholders provided to us on that RFI, we have two specific proposals to reduce burden, starting next year.

First, regarding flexibility for radiologists' assistants, we're proposing to revise the physician supervision requirement so that any diagnostic tests that is performed by a radiologist assistant may be furnished under, at most, a direct level of physician supervision when that test is performed by a radiologist's assistant in accordance with state law and state scope of practice rules.

We believe that reducing the required level of supervision will greatly improve the efficiency of care furnished by these practitioners as well as by radiologists. The other area that we're proposing to reduce burden is that we are proposing to discontinue the functional status reporting requirements for outpatient therapy. Since January 1 of 2013, as required by the law, all providers of outpatient therapy services have been required to include functional status information on claims they submit to Medicare for therapy services.

So CMS implemented this system to collect data using non-payable HCPCS G codes and modifiers to implement these requirements and again, in response to comments that we received on the RFI last year, we are proposing to eliminate the requirement that providers include functional status reporting for services that are furnished on or after January 1, 2019.

Next we wanted to highlight for you a couple of RFIs that we are including for 2019. The first one is related to advancing My Health e-data. In addition to the payment policy proposals, we want to get your feedback on positive solutions to better achieve inter-operability or the sharing of health care data

between providers. Specifically we are requesting stakeholder feedback through an RFI on the possibility of revising conditions of participation related to inter-operability as a way to increase electronic sharing of data by providers.

And the hope is that the information we receive will inform next steps to advance this critical initiative. And of course in responding to the RFI we're encouraging commenters to provide clear and concise proposals that include data as well as specific examples. Our intention is not to respond to RFI comment submissions in the subsequent PFS final rule, but rather we will actively consider all input in developing future regulatory proposals or future sub-regulatory guidance.

And now I wanted to pass it to my colleague Dr. Terri Postma for information on another RFI.

Dr. Postma: Hi, I'm Terri Postma, Medical Officer in the Centers for Medicare. And through a price transparency RFI in this proposed rule, we're seeking your thoughts on how we can together empower consumers through better transparency of prices for health services.

When Secretary Azar took office at HHS, he identified using value-based transformation of our entire health care system as one of the top four priorities for our department, including giving consumers greater control over health information and encouraging transparency from providers and payers.

Increasing quality, improving outcomes and lowering costs aren't new concepts. We've long talked about the need to move towards a more sustainable system, one that pays for value and not merely volume. And some progress has been made, but if we're going to take the final steps, we must

activate that most important force in our health care system for creating value, the patient.

In virtually every sector of the economy, you're aware of the cost of the service before you purchase it, except for health care. Patients deserve and need to know the cost of services if they're going to be empowered to shop for value. We believe that the system can only be fixed by placing patients at the center of cost and quality decisions, empowered with the information they need to make the best choices for themselves and their families.

This means that providers and insurers must become more transparent about their pricing. There's no more powerful force than an informed consumer. Through this empowerment, there will be competitive advantage amongst providers to deliver coordinated, quality care at the best value to attract patients who are shopping for high-quality care.

Some insurers and employers have already taken steps to promote transparency in prices, including developing tools that show people what different local providers charge for a procedure. CMS has also taken some steps. For example, CMS is expanding the data we make available to researchers through public use files. We're taking an API approach to modernizing how we exchange data with our partners, and as noted in this RFI, we recently updated our hospital charge master guidelines to require hospitals to post their charges online in a machine-readable format.

We know these initial steps don't fully address patient needs, but we're just getting started and through a request for information such as the one in this proposed rule, we're asking you, the public, for ideas about what additional information patients need to make informed decisions about their care. We need your ideas and input. We need the benefit of your individual expertise

and experience, and we look forward to hearing from you on this important initiative. Thanks, Marge.

Marge Watchorn: Thank you, Terri, and this is Marge Watchorn again. Just wanted to reiterate for those who may have joined a few minutes late, I know we've had an awful lot of interest in the call today, and again want to thank you all for participating. And certainly we have some of the key experts here available to answer questions that you might have today.

But I would just strongly encourage all of you, if you have questions, concerns, areas of the rule that you've read that you believe we could clarify better, strongly encourage you to follow the instructions in the early pages of the proposed rule where we give instructions for submitting formal public comments.

Again, comments are due on Monday, September 10, and it's very important for purposes of the public record as well as our rulemaking process that we have all of your comments submitted through the formal process to give us the ability to consider them as we're finalizing any of these proposals in the final rule.

Jill Darling: All right, thanks Marge, and thank you to all of our speakers today in the room with us and on the phone. Kevin will open the lines for Q and A please.

Coordinator: Thank you. At this time if you would like to ask any questions over the phone lines, please press Star then 1 on your touch-tone phone. Be sure your phone line is unmuted and state your name at the prompt so we can announce your name prior to you asking your question. Again, press Star then 1 on your touch-tone phone if you'd like to ask any questions. And your first question comes from (Ted Gaines), your line is open, sir.

(Ted Gaines): Thanks, CMS, for the opportunity to ask a question. You're proposing on page 376 to revise the teaching physician standards. Two questions, one, it appears based on the proposal that you're retaining the performance requirement for teaching physician services in evaluation of management codes, but you're changing the documentation standard. Is that a correct understanding, number one?

And number two, the proposal seems to focus on the evaluation of management service and not on procedures. Are you proposing to change the documentation standard for procedures as well, for example the difference between minor procedures and major procedures? Thank you.

Marge Watchorn: This is Marge Watchorn, thank you so much for that question. Unfortunately, we don't have the right subject matter expert on the line for you today. I would encourage you to, you know, again review the rule as it's quite apparent to me that you've done. Definitely encourage you to submit a formal comment to us so that to the extent anything we have proposed is unclear that we could have the opportunity to make it more clear in the final rule.

Coordinator: Thank you. Your next question is from (Allison Brennan), your line is open, ma'am.

(Allison Brennan): Great, thank you very much. My question is related to the MAQI demonstration. I'm wondering if providers participating in that demonstration can become eligible to be QPs and earn the advanced APM bonus solely through their participation with qualifying Medicare Advantage advanced APMs. In other words, can they earn the bonus through that demonstration without having participation in a Medicare advanced APM. Thank you.

Laurie McWright: Hi, this is Laurie McWright, and no, they cannot.

(Allison Brennan): Okay, thank you.

Coordinator: Thank you. Your next question is from (Janine Angle). Your line is open.

(Janine Angle): Hi, thank you for taking questions. So you are proposing to reduce rates, payment rates by 50% for zero-day global procedures performed on the same day as E&M. I would assuming it would be E&M most of the time that's reduced. But in the proposed rule the way it's phrased is that it would be for any second visit or service. And my question is, whether that then would apply to things like annual wellness visit plus E&M billed on the same day.

Marge Watchorn: Hi, this is Marge Watchorn, thank you for the question. I'm not sure that we have specifically contemplated the applicability of the policy to the annual wellness visit, so I'm probably going to sound like a broken record, but I would encourage you to submit that question through the formal comment process. So that we can take that under consideration for the final rule.

(Janine Angle): Okay, thank you.

Marge Watchorn: Thank you.

Coordinator: Your next question comes from (Janet Lambert). Your line is open.

(Janet Lambert): Thank you so much for taking my question. It kind of is following the same guidelines or question that was just asked about the E&M service with the procedure. Are you thinking about doing away with Modifier 25 and changing the guidelines of it being a separate identifiable E&M with a procedure?

Marge Watchorn: Thank you for the question. I'm actually going to ask if one of my colleagues, Emily Yoder, happens to know the answer to that question. She's also on the line.

Emily Yoder: Yeah, hi, thank you so much for that question. We are not proposing to do away with Modifier 25, that's the mechanism by which a separately identifiable evaluation management visit performed on the same day as a procedure is identified. So we are not proposing to eliminate that modifier at this time.

(Janet Lambert): Thank you, can I, do you mind if I ask just another quick question about the, doing the medical decision-making as the primary reason to do an E&M service. Are you, would you propose to use the same guidance of presenting problem, diagnostic testing and risk factors?

(Ann Marshall): Hi, this is (Ann Marshall). So if you choose to, under the proposal if you chose, if a practitioner chose to document using medical decision-making, they would be using medical decision-making as it's currently, in its current form. And but then we did solicit comments on ways in which we might change the medical decision-making parameters or kind of variables in subsequent years because of all of the comments we heard after last year's proposed rule and response that medical decision-making might need to be altered going forward.

(Janet Lambert): Thank you very much.

Coordinator: Your next question is from (Matthew Appel), your line is open.

(Matthew Appel): Hi, can you hear me?

Coordinator: Yes, sir, go ahead.

(Matthew Appel): Okay, I just had a question about tele-medicine. I was trying to follow everything that was said, but in order for us to bill for tele-medicine, do we have to be located in a qualified location like a rural, a designated rural location, or do our patients have to be located in some specific type of qualified location? Thank you.

Marge Watchorn: Hi, thank you for the question, this is Marge Watchorn. Except for the two specific provisions that I described briefly that were in the Bipartisan Budget Act of 2018 relating to ESRD services as well as acute stroke services, there's really no other changes to the underlying statutory framework regarding Medicare payment under Part B for services furnished via tele-health.

One of those requirements is that the patient be located at a qualifying originating site and there's in the statute certain geographic criteria that must be met in order for the patient to receive those services. Does that answer your question?

(Matthew Appel): Yes. I'll just have to refer to the actual statutory, I just thought maybe that if I were to go to those rules that the provisions you described might have changed them or altered them in some way.

Marge Watchorn: Not the underlying requirements for Medicare tele-health. The Bipartisan Budget Act only changed requirements for individuals receiving ESRD services in their home. As well as individuals exhibiting symptoms of acute stroke. And all of those changes are described in detail in the proposed rule.

(Matthew Appel): Great, thank you, and just another quick question. I, the ancillary documentation requirement that changed, it sounds to me like the provider

will just have to confirm or agree or whatever, acknowledge the ancillary staff's documentation, but my understanding is that only review of systems can be entered by ancillaries. So is there going to be an expansion of what an ancillary staff is allowed to document? And that's my last question, thank you.

(Ann Marshall): Hi, this is Ann Marshall, I believe the proposal was for them to be allowed to document (unintelligible) and history. But if you submit that question, I will take a look back more carefully at the language. Why don't you send us an e-mail on that one, please?

(Matthew Appel): What's the address?

Marge Watchorn: You can send that question to me, e-mail address is Marge, M-A-R-G-E, dot Watchorn, W-A-T-C-H-O-R-N, as in Nancy, @cms.hhs.gov. Also wanted to note that in the proposed rule is a long list of all of the subject matter experts, so if, for those who are on the line if you don't get a chance to ask your question, you could always refer to the list of contacts that are in the proposed rule and folks can, you know, to get your questions answered in that manner.

Jill Darling: And (Kevin), we'll take one more question, please.

Coordinator: Certainly, ma'am. Your next question is from Catherine Hill, your line is open.

Catherine Hill: Hi, this is Catherine Hill with the American Association of Neurological Surgeons and the Congress of Neurological Surgeons, and my question is about the ENM documentation. And you know, it's quite a huge proposal, so we are concerned about the January 1 proposed adoption date. We're also concerned about how the AMA CPT and (unintelligible) were involved in

setting this, these new rates for E&M, the one blended payment and hope that going forward, CMS will work very closely with them.

And another concern is the impact tables, while they, you know talked about the special impact, we're concerned about the individual practitioner who has very complex patients and, you know, bills typically the level four and the level five, that the individual may have a higher negative impact than this, you know, specialty as a whole.

But my real question is whether you all have thought about the impacts throughout the fee schedule and particularly any plans about the global surgical periods and the E&M work in those periods.

Marge Watchorn: Thank you for those questions, I heard about maybe three or four different topics there, so very cleverly worded question. But all joking aside, you know these proposals were developed by CMS in conjunction with our partners at the Department of Health and Human Services.

You know, the payment proposal that you alluded to that we didn't discuss today where the payment is combined, it's currently paid levels two through five. We did a weighted average based on utilization and came up with a blended payment amount that equates to roughly level 3.6.

We recognize as you correctly note that a practitioner who today typically bills at levels four and five will see a reduction in their payment if they're going to be paid at a level approximately 3.6, and in an effort to recognize you know potential payment disparities, we have proposed as described briefly by me the two add-on payments, and based on our modeling as described in the impact section, the hope is that the use of the add-on payments where

appropriate could potentially offset some of the potential losses that an individual practitioner might see.

In terms of the involvement of the AMA, you know there's certainly and the (unintelligible) they are certainly, you know, a valuable stakeholder as all stakeholders are extremely valuable, and we consider their comments on the rule as carefully as we consider all the comments that we receive, and I think there might have been more to your question.

Catherine Hill: This level surgical package going forward, the E&M work, if you all have thought of that. I mean may not be planning anything at this time but I just kind of wondered, you know, what your thoughts were on that.

Marge Watchorn: Sure, thank you for that. Great question, and you know I don't think we stated anything about the applicability to the evaluation of global surgical packages, so I would certainly, if that's something that you believe the agency should consider for future rulemaking I would absolutely include that in a public comment.

Catherine Hill: Great, thank you very much.

Marge Watchorn: Sure.

Jill Darling: All right, thank you everyone, this concludes today's Physicians Open Door Forum. We appreciate you listening and the comments and questions asked in the Q and A. So thanks everyone, have a great day.

Coordinator: Thank you. This ends today's conference. You may disconnect your lines. Have a good day. Speakers, one moment for your post-conference.

END