CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMO UPDATE
REGION IX MEDICAL ASSOCIATION TELECONFERENCE

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This publication is a general summary that explains certain aspects of the Medicare Program, but is not a legal document. The official Medicare Program provisions are contained in the relevant laws, regulations, and rulings. Medicare policy changes frequently, and links to the source documents have been provided within the document for your reference

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Objectives

- CMS Strategic Goals
- Burden Reduction & Patients over Paperwork
- Update: The 2019 Physician Fee Schedule Final Rule
- Update: The Opioid Epidemic and the SUPPORT Act
- Q&A

CMS Strategic Goals

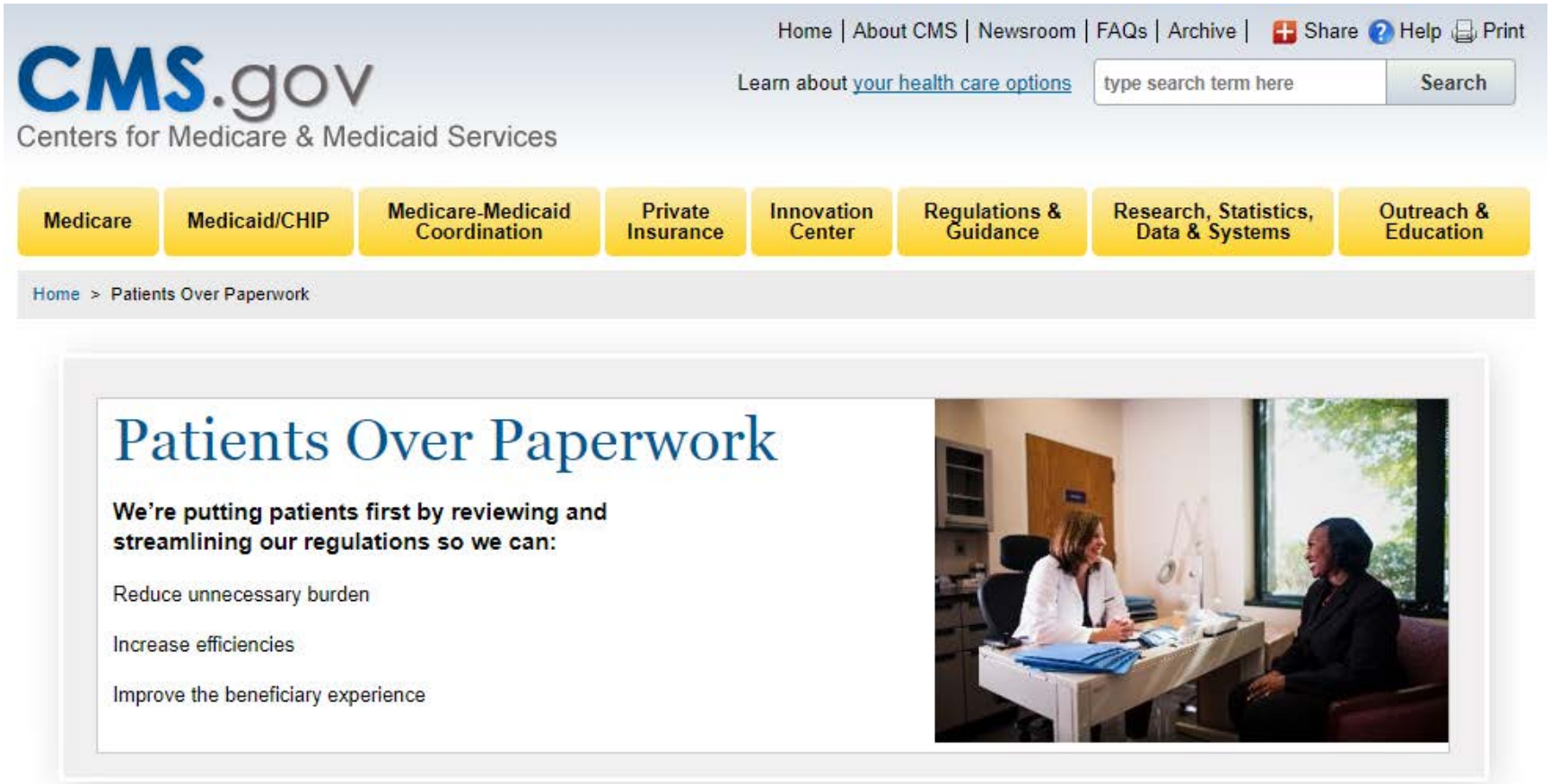
1. Empower patients and clinicians to make decisions about their health care.

2. Usher in a new era of state flexibility and local leadership.

3. Support innovative approaches to improve quality, accessibility, and affordability.

4. Improve the CMS customer experience.

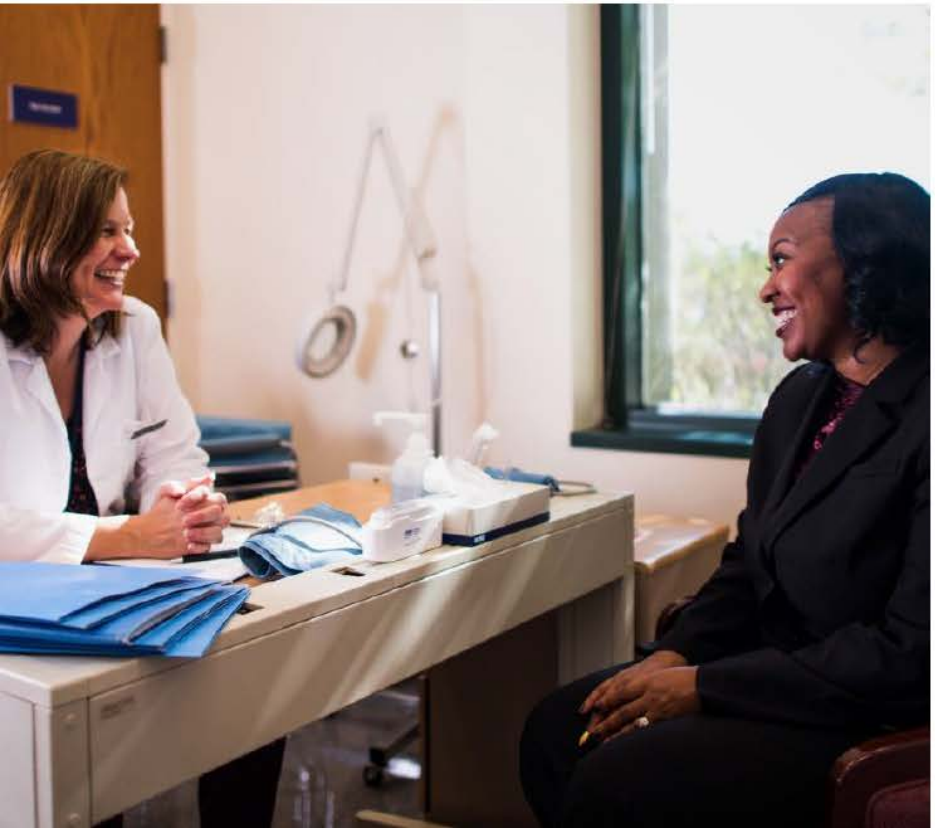
PATIENTS OVER PAPERWORK



https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html

PATIENTS OVER PAPERWORK

Some of CMS' Burden Reduction Initiatives include:



1. Quality and Safety Oversight Requirements
2. Electronic Health Record (EHR) Projects
3. Documentation Requirements Simplification (DRS) Initiative

https://www.cms.gov/About-CMS/story-page/patients-over-paperwork.html

Documentation: what we've heard

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.**

ReducingProviderBurden@cms.hhs.gov

https://go.cms.gov/cpi

2019 Physician Fee Schedule Final Rule

Published November 1, 2018

For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare. For CY 2019 and beyond, CMS is finalizing the following policies:

- ✓ **Elimination of the requirement to document the medical necessity of a home visit** in lieu of an office visit;
- ✓ For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may **choose to focus their documentation on what has changed since the last visit**, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;

2019 Physician Fee Schedule Final Rule (cont)

Published November 1, 2018

- ✓ Additionally, we are clarifying that for E/M office/outpatient visits, for new and established patients for visits, **practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary**. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information;
- ✓ **Removal of potentially duplicative requirements for notations** in medical records that may have previously been included in the medical records **by residents or other members of the medical team** for E/M visits furnished by teaching physicians.

Virtual Care: Physician Payment for Communication Technology-Based Services

2019 Physician Fee Schedule Final Rule

CMS is finalizing our proposals to pay separately for two newly defined physicians' services furnished using communication technology:

- ✓ Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012) and
- ✓ Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010)
- ✓ Practitioners could be separately paid for the brief communication technology-based service when the patient checks in with the practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. This would increase efficiency for practitioners and convenience for beneficiaries.

https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year

2019 Physician Fee Schedule Final Rule (cont)

Published November 1, 2018

Beginning in CY 2021, CMS will further reduce burden with the implementation of payment, coding, and other documentation changes. Payment for E/M office/outpatient visits will be simplified and payment would vary primarily based on attributes that do not require separate, complex documentation. Specifically for CY 2021, CMS is finalizing the following policies:

- ✓ Reduction in the payment variation for E/M office/outpatient visit levels by **paying a single rate for E/M office/outpatient visit levels 2 through 4** for established and new patients while **maintaining the payment rate for E/M office/outpatient visit level 5** in order to better account for the care and needs of complex patients;
- ✓ Permitting practitioners to **choose** to document E/M office/outpatient level 2 through 5 visits **using medical decision-making or time** instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners **could continue using the current framework**;

E/M Payment Add-On Codes

2019 Physician Fee Schedule Final Rule

New Primary Care Complexity Code:

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 level 2 through 4 office/ outpatient evaluation and management visit, new or established)

New Non-procedural Specialty Care Complexity Code:

Visit complexity inherent to evaluation and management associated with non-procedural specialty care including endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonology. (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

New Extended Visit Code:

Extended time for evaluation and management service(s) in the office or other outpatient setting, when the visit requires direct patient contact of 34-69 total face-to-face minutes overall for an existing patient or 38-89 minutes for a new patient (List separately in addition to code for level 2 through 4 office or other outpatient Evaluation and Management service)

Existing Prolonged Services Code:

Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)

E&M Payment Amounts

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

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.
Physician groups have routinely complained to CMS that billing prolonged with any regularity tends to prompt medical review and is ultimately cost-prohibitive.

**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.

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

For more information….

To view the CY 2019 Physician Fee Schedule and Quality Payment Program final rule, please visit: https://www.federalregister.gov/public-inspection/

For a fact sheet on the CY 2019 Physician Fee Schedule final rule, please visit: https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year

For a fact sheet on the CY 2019 Quality Payment Program final rule, please visit: https://www.cms.gov/Medicare/Quality-Payment-Program/Quality-Payment-Program.html

For a chart on E&M payment amounts, please visit: https://www.cms.gov/sites/drupal/files/2018-11/11-1-2018%20EM%20Payment%20Chart-Updated.pdf

https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf

CMS Roadmap

TO ADDRESS THE **OPIOID EPIDEMIC**

Opioids killed more than 42,000 in 2016, or 116 people a day.[2]

40% of all opioid overdose deaths involve a prescription opioid.[1]

PREVENTION

Manage pain using a safe and effective range of treatment options that rely less on prescription opioids

TREATMENT

Expand access to treatment for opioid use disorder

DATA

Use data to target prevention and treatment efforts and to identify fraud and abuse

PRESCRIPTION OPIOID MISUSE

When used correctly, prescription opioids are **helpful** for treating pain.

The CDC outlined **guidelines** for safe prescribing of opioids.

An estimated **11.5 million** people misused prescription opioids[2]—putting them at risk for dependence and addiction.

3 out of 4 people who used heroin misused prescription opioids first.[3]

OPIOID USE DISORDER

Over **two million** people suffer from opioid use disorder.

Treatment **options** exist, including medication-assisted treatment (MAT).

Only 20% of people with opioid use disorder receive treatment.[3]

Learn more about prescription opioid misuse

Learn more about opioid use disorder and treatment

CMS Roadmap to Address the Opioid Epidemic

KEY AREAS OF CMS FOCUS

As one of the largest payers of healthcare services, CMS has a key role in addressing the opioid epidemic and is focused on three key areas:

PREVENTION

Manage pain using a safe and effective range of treatment options that rely less on prescription opioids

TREATMENT

Expand access to treatment for opioid use disorder

DATA

Use data to target prevention and treatment efforts and to identify fraud and abuse

https://www.cms.gov/About-CMS/Agency-Information/Emergency/Downloads/Opioid-epidemic-roadmap.pdf

CMS Roadmap: Next Steps

MOVING **FORWARD**

PREVENTION

Significant progress has been made in identifying overprescribing patterns

TREATMENT

Medicare, Medicaid, and private health plans provide some coverage for pain and opioid use disorder treatments

DATA

Data provides insight into doctor, pharmacy, and patient use of prescription opioids and effectiveness of treatment

CMS CAN BUILD ON THESE EFFORTS TO FURTHER:

1. **Identify** and stop overprescribing of opioids
2. **Enhance** diagnosis of OUD to get people the support they need earlier
3. **Promote** effective, non-opioid pain treatments

1. **Ensure** access to treatment across CMS programs and geography
2. **Give** patients choices for a broader range of treatments
3. **Support** innovation through new models and best practices

1. **Understand** opioid use patterns across populations
2. **Promote** sharing of actionable data across continuum of care
3. **Monitor** trends to assess impact of prevention and treatment solutions

SUPPORT for Patients and Communities Act

https://www.congress.gov/bill/115th-congress/house-bill/6

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

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

- Additionally, the SUPPORT for Patients and Communities Act **establishes a new Medicare benefit category for opioid use disorder treatment services furnished by opioid treatment programs (OTP) under Medicare Part B**, beginning on or after January 1, 2020. We note that **there is a 60-day period to comment on the provisions of the interim final rule**, during which we are requesting information regarding services furnished by OTPs, payments for these services, and additional conditions for Medicare participation for OTPs that stakeholders believe may be useful for CMS to consider for future rulemaking to implement this new Medicare benefit category.

- To provide comment, please see the first two pages of the 2019 PFS Final Rule: https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

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