# CMS Final Rule Updates & What is MIPs?


January 19, 2019

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# What is the Final Rule?


Over 900 pages!

VCU Health

# Federal Register – Executive Summary

## I. Executive Summary

### A. Purpose

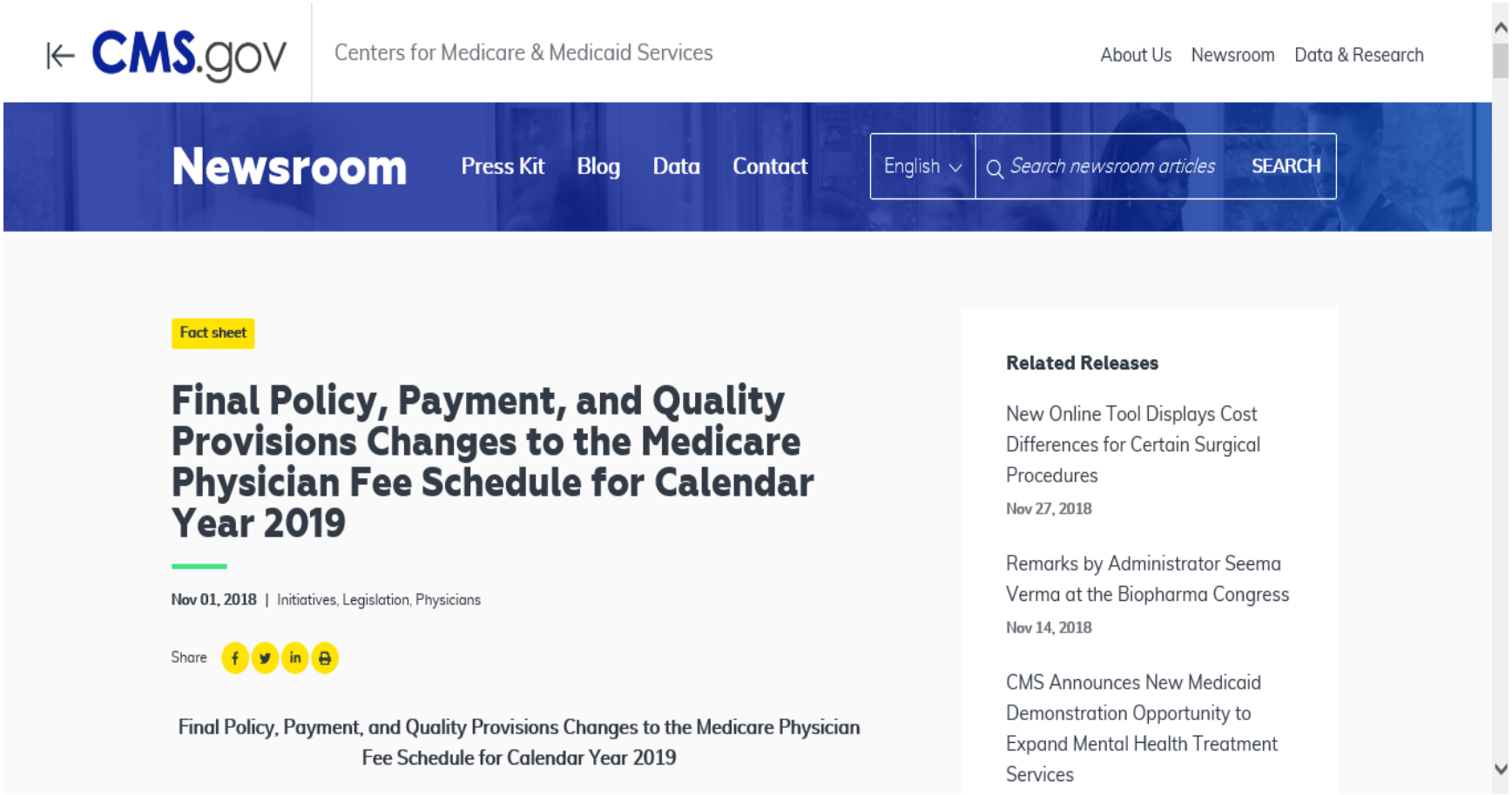
This major final rule makes payment and policy changes under the Medicare PFS and implements certain provisions of the Bipartisan Budget Act of 2018 (Pub. L. 115-123, February 9, 2018) and the SUPPORT for Patients and Communities Act (Pub. L. 115-271, October 24, 2018) related to Medicare Part B payment, and except as specified otherwise, applicable to services furnished in CY 2019. This final rule also revises certain policies under the Medicare Shared Savings Program.

# Why do we have a Final Rule?

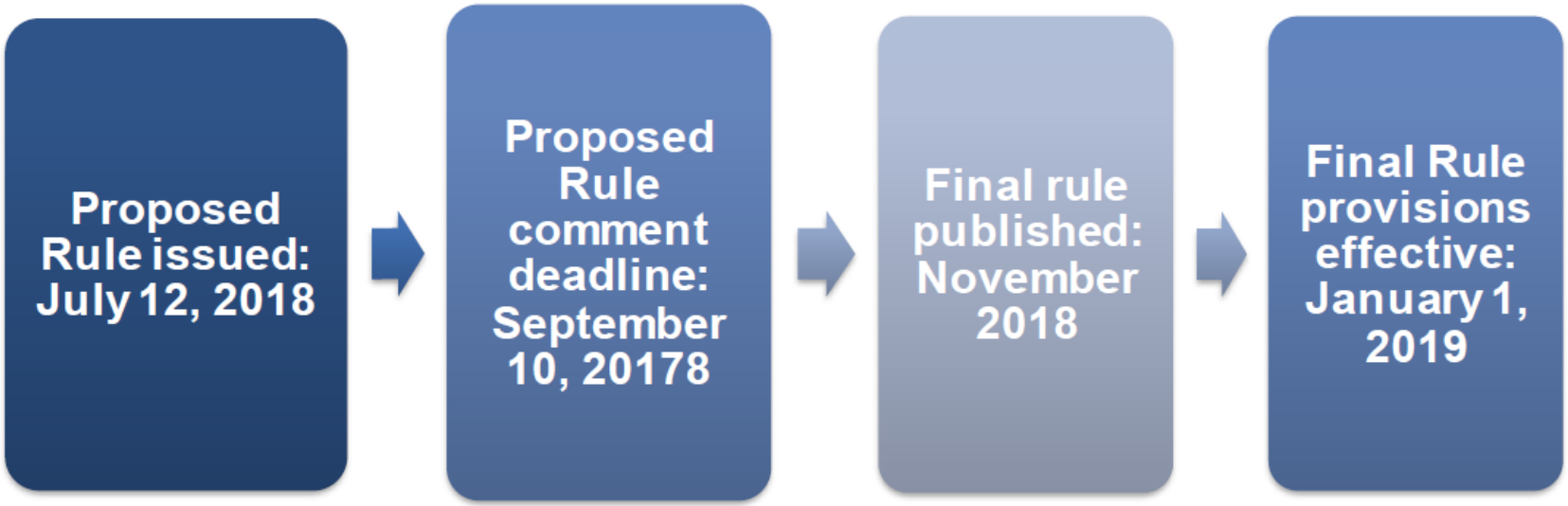
**Summary of the Major Provisions**

The statute requires us to establish payments under the PFS based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service. The statute requires that RVUs be established for three categories of resources: Work; practice expense (PE); and malpractice (MP) expense. In addition, the statute requires that we establish by regulation each year's payment amounts for all physicians' services paid under the PFS, incorporating geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas. In this major final rule, we establish RVUs for CY 2019 for the PFS, and other Medicare Part B payment policies, to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in the statute.

# Is there a better way?



# Final Rule Timeline for 2018



***Proposed*** Rule
Published July 12, 2018
Changes for E&M and Documentation Requirements

https://www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

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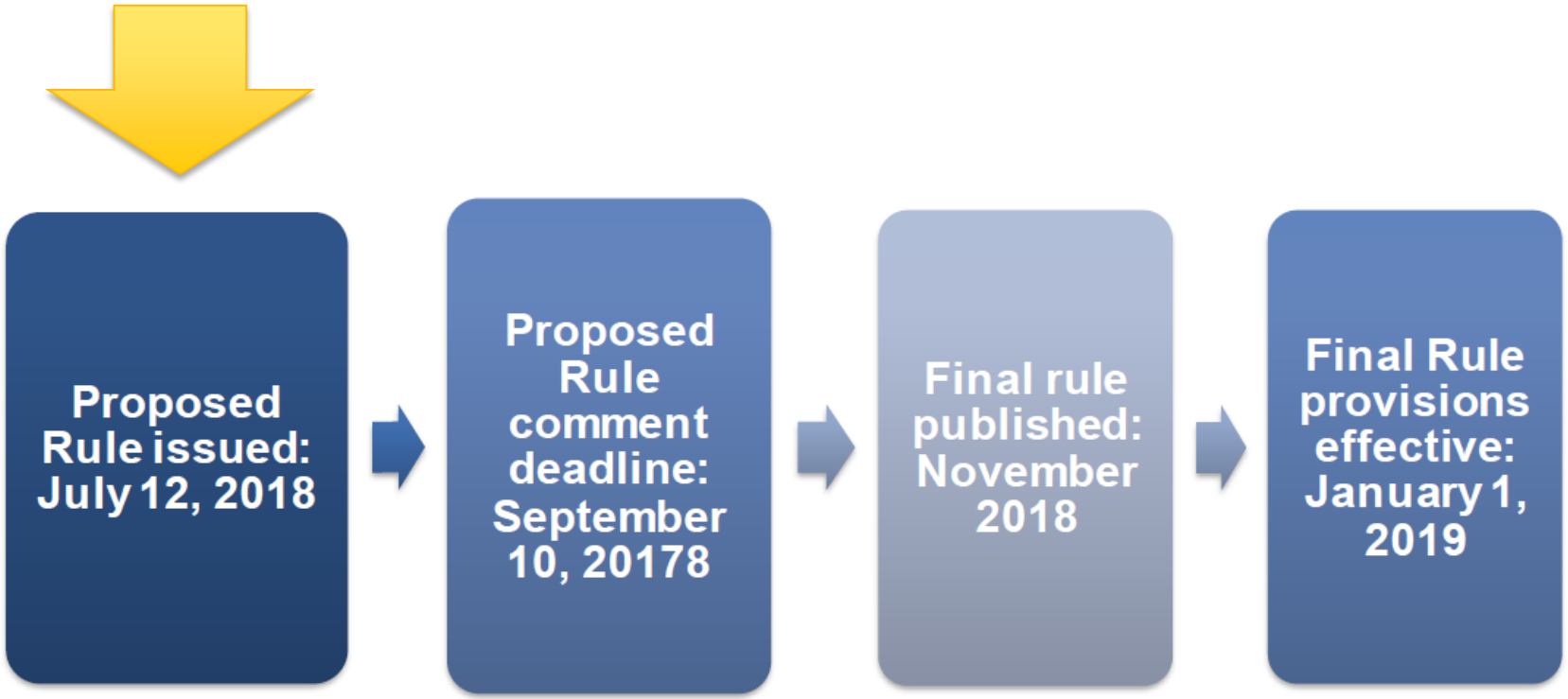


# Eliminating Extra Documentation Requirements for Home Visits

CMS is proposing to remove the requirement that the medical record must document the medical necessity of furnishing the visit in the home rather than in the office

# Eliminating Prohibition on Billing Same-Day Visits

Currently, CMS prohibits payment for two E/M visits billed by a physician (or physician in the same practice) for the same beneficiary on the same day.

CMS has proposed eliminating this policy.

# Proposed Changes to Documentation Requirements

Physicians will be allowed to choose the method of documentation:

1. 1995 or 1997 Evaluation & Management Guidelines for history, physical exam, and medical decision making (current framework)
2. Medical decision making only
3. Physician time spent face-to-face with patients

(Propose that physicians would only need to document level 2 visit)

# Removing Redundancy in E&M Visit Documentation

CMS proposes to expand the current policy that the billing provider is not required to repeat the documentation for "Review of Systems" and/or pertinent past, family, or social history (PFSH) obtained during an earlier encounter.

If there is evidence that the provider reviewed/updated the information, they would not need to re-record the elements.

# Teaching Physician Documentation for E&M Services

CMS proposes to revise regulations that require medical records to document that the teaching physician was present at the time of service.

The presence of a teaching physician during the E/M service may be demonstrated by notes in the medical record made by a physician, resident or nurse.

# Proposed Changes for Outpatient E&M Codes

CMS is proposing a single, blended payment rate for E/M codes levels 2 through 5 for established patients (99212-99215) and new patients (99202-99205).

CMS proposes to make other adjustments through add-on payments and MPPR for payment accuracy.

# Time as a Basis for Payment

CMS is soliciting comments on what total time should be used for the new single, blended payment rate for E/M codes levels 2-5, if time were to be the basis of payment.

# New Add-on CPT Codes for Outpatient E&M Services

Along with the changes to a single payment rate for E/M codes levels 2-5, CMS has proposed three new add-on G-codes.

- Inherent Complexity
- Primary Care
- Prolonged Services

# New Add-on G-Code: Primary Care

**GPC1X** Visit Complexity inherent to E/M associated with **primary care services** that serve as the continuing focal point for all needed health care services

Additional Payment: ~ $5
What makes it more complex?

# New Add-on G-Code: Specialty Care

| | |
|---|---|
| GCG0X | Visit complexity inherent to E/M services associated **with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care.** |

Additional Payment: ~ $14
What makes it more complex?
Not all specialties are listed (e.g. Palliative Care, Orthopedics,etc.)

# New Add-on G-Code: Prolonged Services

| | |
|---|---|
| GPRO1 | Prolonged E/M or psychotherapy services (List separately in addition to code for office or other outpatient E/M or psychotherapy service ) |

Additional Payment: ~ $67
Would be used for any office visit lasting more than 30 minutes beyond visit. Can it be used if counseling was done in E&M visit?
Psychiatrist would use 98075 and not this code

# Outpatient E&M Multiple Procedure Payment Reduction (MPPR)

Proposes to reduce payment by 50% for the least expensive procedure/visit that the same physician provides on same day as E&M service

CMS notes that the MPPR reductions would be used to fund the new add-on payment for E/M codes.

Similar to multiple surgery reductions

# New Codes for Interprofessional Consultation

- CMS proposed payment for two new CPT codes for eConsults, that CMS would cover beginning January 1, 2019.
- CMS will allow payment for 4 revised codes (99446, 99447, 99448, and 99449) for Interprofessional consult services– these include verbal reports).
- Proposal is open for public comment until September 10, 2018.

Codes would pay both the referring provider and consultative specialist

# Guidelines for Using New Interprofessional Codes

- **No use** of these codes **if patient sees specialist** within 14 days before or after eConsult
- Only **one use** of the code per patient per 7 days
- Ok for patients **with or without a relationship** with the specialist, if a new or exacerbation of existing problem
- No to be used when "sole purpose" of communication is to arrange a referral for an in-person visit

# What about patient responsibility for these services?

- The adoption of these codes would lead to the patient pay additional co-insurance on 2 separate services
- Patient would never see “specialist” yet receive a bill
- How do you notify the patient?

# Virtual Outpatient Services

Brief communication technology based service, e.g. virtual check-in provided by a physician or other qualified health care professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days, not leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minute of medical discussion.

Telemedicine versus Virtual Medicine?

# Evaluation of Pre-Recorded Patient Information

CMS proposes to create specific coding that describes the remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology.

Services are intended to determine whether or not office visit or other service is warranted.

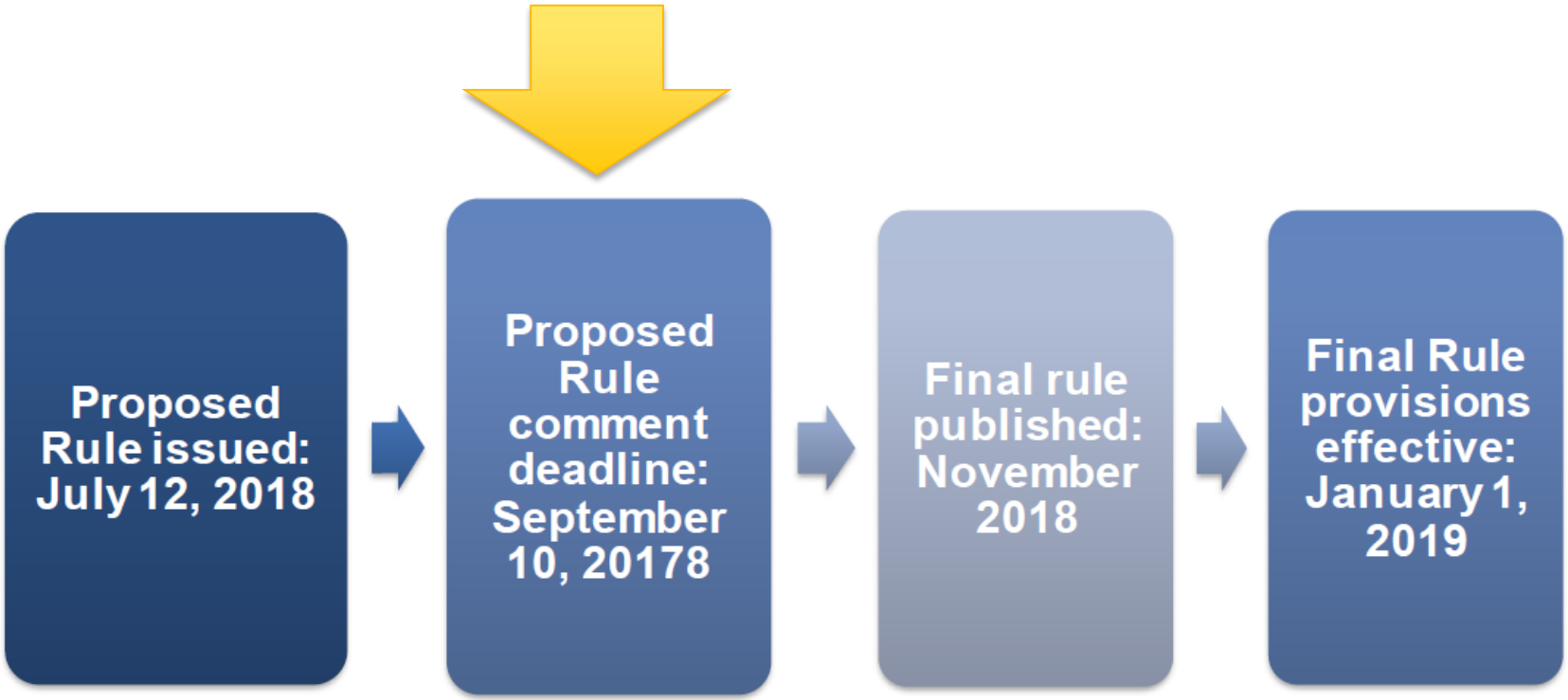
Can be separately billed if no resulting E/M office visit and no related E/M visit within previous 7 days.

# Implementation

CMS is proposing new policies would be implemented Jan 1, 2019, but notes it considered a multi-year or delayed effective date.

# Comment Period

# Final Rule Timeline for 2018



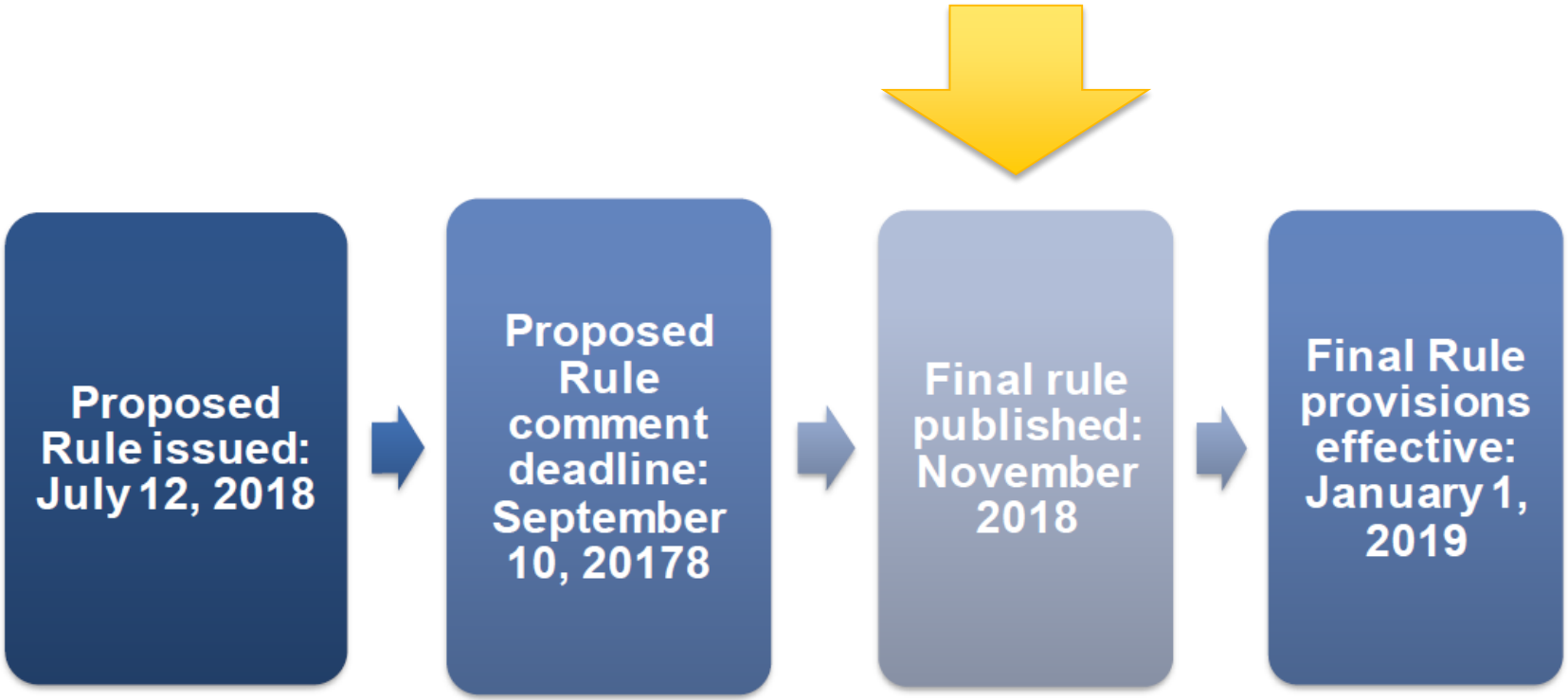
# Majority of Groups are Opposed to CMS' E/M Payment Change Proposals

- AHIP
- BCBSA
- Anthem
- American Medical Association
- Virtually Every Physician Specialty Group

# FINAL RULE

Displayed : November 1
Published:  November 23

# Final Rule Timeline for 2018



# Eliminating Extra Documentation Requirements for Home Visits

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**Final Rule:**

**CMS approved for 1/1/19**

# Eliminating Prohibition on Billing Same-Day Visits

Currently, CMS prohibits payment for two E/M visits billed by a physician (or physician in the same practice) for the same beneficiary on the same day.

CMS has proposed eliminating this policy.

**Final Rule:**
**Did not finalize. No change for 1/1/19**

# Proposed Changes to Documentation Requirements

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**Final Rule:**

**CMS approved for 1/1/19**
**Dependent on Practice Documentation Policy**

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CMS proposes to make other adjustments through add-on payments and MPPR for payment accuracy.

**Final Rule:**

**CMS approved for 1/1/21 for blended payment and add-on codes**

# Time as a Basis for Payment

CMS is soliciting comments on what total time should be used for the new single, blended payment rate for E/M codes levels 2-5, if time were to be the basis of payment.

**Final Rule:**

**CMS received comments but did not issue any guidance**

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**Final Rule:**

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**Final Rule:**

**CMS did NOT implement due comments received**

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**Final Rule:**

**CMS approved for 1/1/19**
**Code G2012**

# Virtual Visits Clarified

Service billable when physician or qualified health care professional has a brief non-face-to-face check-in with patient via communication technology to assess whether patient's condition necessitates office visit.

Only furnished for established patients (expect patient to initiate). No frequency limit.

CMS finalized allowing audio-only, real time telephone calls in addition to video.

CMS will require verbal consent from the beneficiary that is noted in the medical record.

# Evaluation of Pre-Recorded Patient Information

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**Final Rule:**

**CMS approved for 1/1/19**
**Code G2010**

# MIPS – What is it?

# Economics: Physician Payments

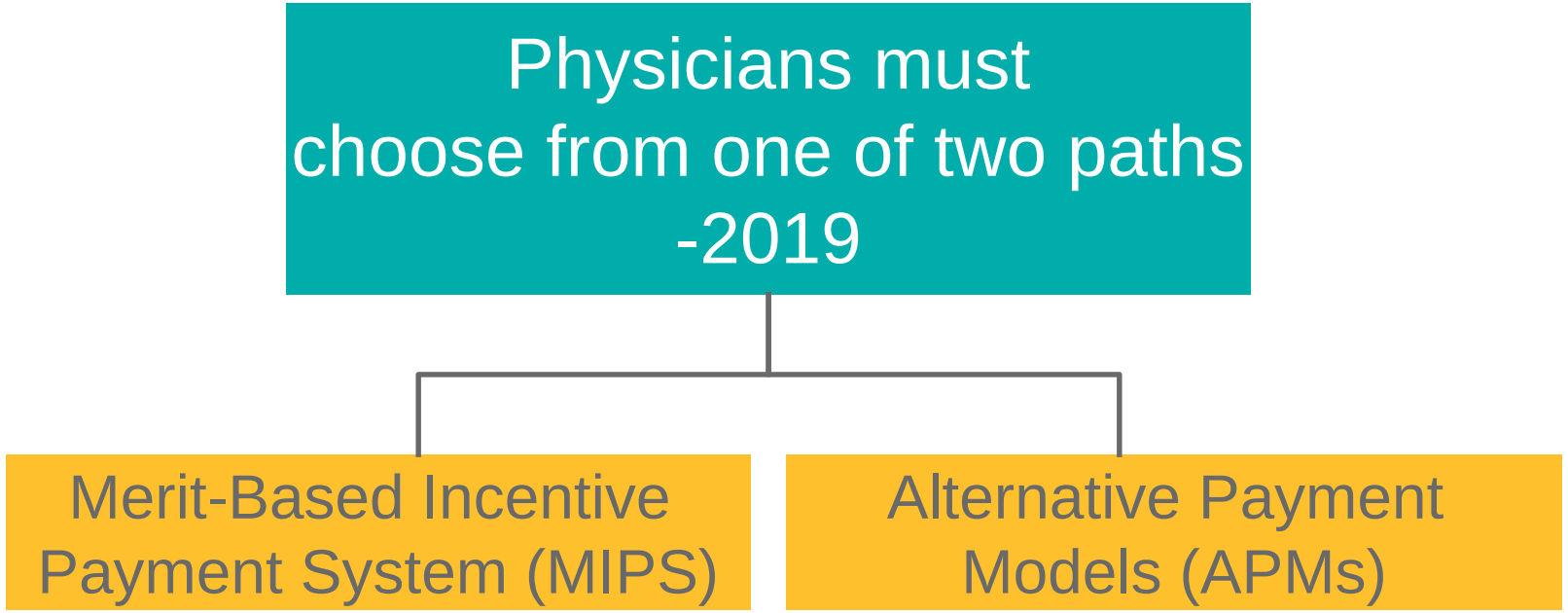
- Sweeping changes to overhaul physician payment
    - Medicare FFS Fee Schedule driven
    - Sustainable Growth Rate (SGR) ends 4/16/2015
- “Permanent Doc Fix” introduced
- Medicare Access & CHIP Reauthorization Act
  aka, MACRA
    - 20B/10y for CHIP
    - 10M/5y for MACRA training
    - Release 11/1/2016 with 2 months to prepare 1/1/2017

”

# Why make this change?

- Current payment levels are NOT sustainable
  - At current spending Medicare will be bankrupt in 2026
- Today 14% of US population is 65 y/o or older
- By 2030 20% of US population will be 65 y/o or older
- Congress cannot politically cut payments
- They need to find a new model
- Based on Quality not Fee for Service

# MACRAnomics – The Basics




- Technically, decision will need to be made much sooner than 2019
- MIPS path for MCVP given rules for APMs (future state)
- At-risk payments in 2019 determined by performance in 2017

# Quality Payment Program

- ✓ **Repeals** the Sustainable Growth Rate (SGR) Formula
- ✓ **Streamlines** multiple quality reporting programs into the new Merit-based Incentive Payment System (MIPS)
- ✓ **Provides incentive payments** for participation in **Advanced Alternative Payment Models (APMs)**

**The Merit-based Incentive Payment System (MIPS)** **or** **Advanced Alternative Payment Models (APMs)**

- ✓ **First step to a fresh start**
- ✓ **We're listening and help is available**
- ✓ **A better, smarter Medicare for healthier people**
- ✓ **Pay for what works to create a Medicare that is enduring**
- ✓ **Health information needs to be open, flexible, and user-centric**

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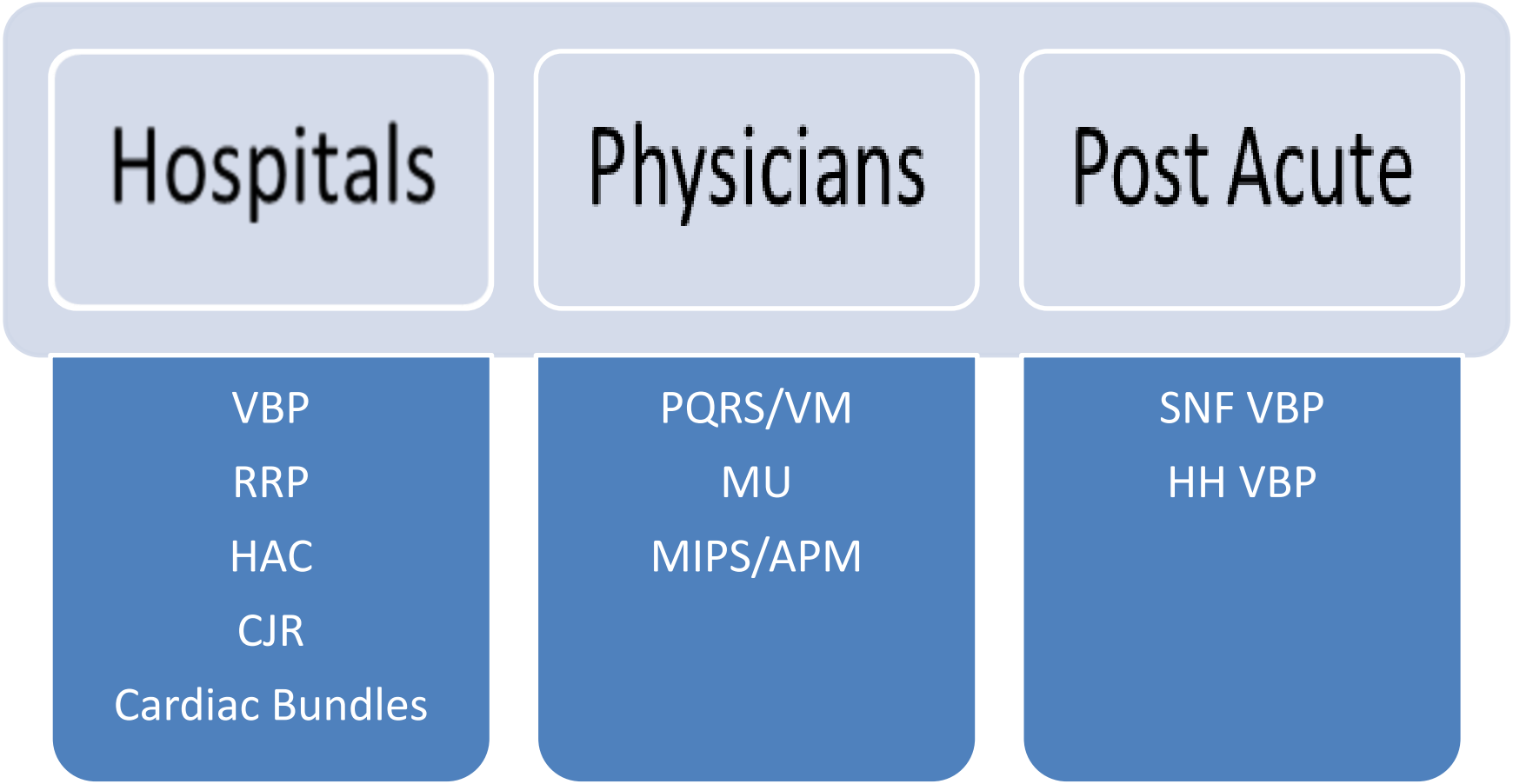
# 2017 and Beyond

- PQRS, VM, and MU will morph into MIPS
  - Group vs Individual Reporting
  - Multiple reporting methods under one TIN
  - Data requirements
  - Details around each new category
- New: Clinical Practice Improvement Category
- No Neutral Zone – threshold based
- Potential penalties lower than in 2016, 4%, but build back to 9%

# Mandatory Payment Reform is Everywhere

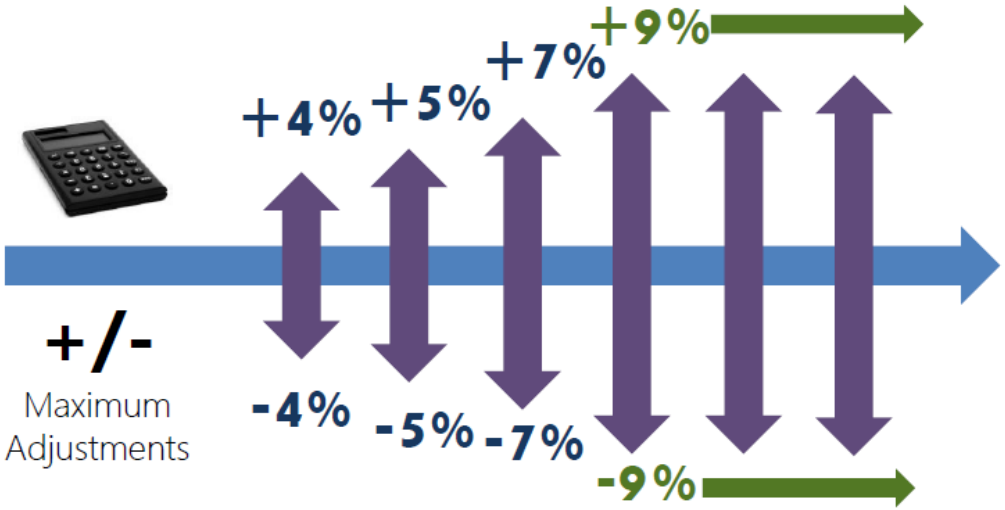


# 4 Performance Groups = 1 **C**omposite **P**erformance **S**core

| Quality | Resource use | Clinical practice improvement activities | Advancing care information | = | MIPS COMPOSITE PERFORMANCE SCORE (CPS) |
|---|---|---|---|---|---|
| PQRS<br>VM<br>eCQM | VM | *New* | MU | | |
| 50% | 10% | 15% | 25% | | |
| 10/meas | 10/meas | 60 max | 100 max | | |

# How much can MIPS adjust payments?

Based on a MIPS Composite Performance Score , clinicians will receive **+/- or neutral** adjustments **up to** the percentages below.




**Adjusted** Medicare Part B **payment** to clinician

The potential maximum adjustment % will increase each year from 2019 to 2022

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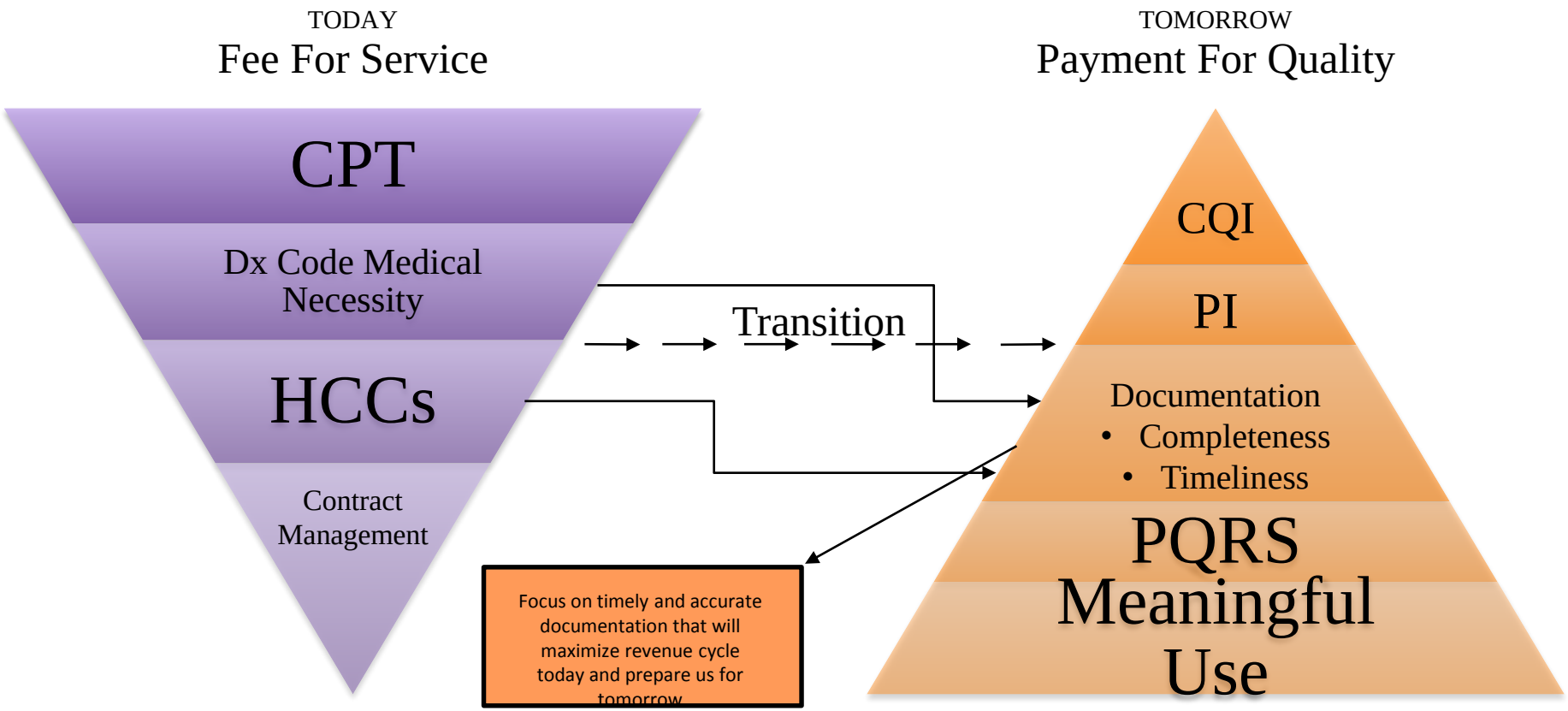
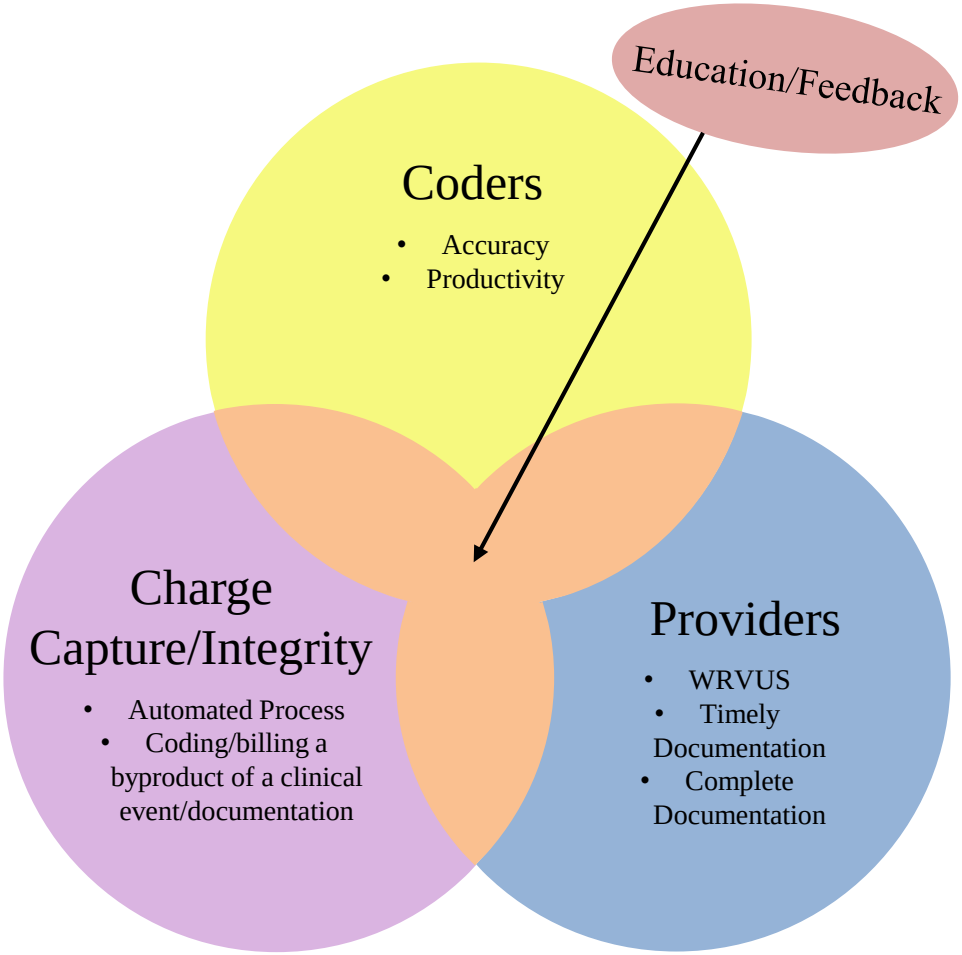
# Changing Reimbursement



# Physician CDI



# Questions?