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Subject: ALL THE NEWS: Physician Fee Schedule, E/M Codes 2021, HOPPS, HCPCS 2020
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E-Reimbursement Newsletter

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Issue: #7 Volume 29 November 2019

Dear Jose Luis,

Hello, readers!!! Guess you all may be thinking I finally retired and rode off into the sunset with a six-pack of Mezcal Margaritas. That is only partially true. Over the past two months, I have been on my Final Speaking Tour of State Society meetings. It has been a lot of bittersweet fun saying a fond farewell to everyone. BUT, that being said, it is not really farewell. It just that I am sick of dirty airports, missed flights, and hotel food.

That being said, in 2020, I will still be available for webinars--both for organizations and for individual offices and clinics. And, there will be places you can see me speak next year, which we will tell you about as they become closer.

And, of course, this crazy newsletter which has been around for thirty years will hopefully be going strong for thirty more years. In fact, we plan to change the format and the content of this publication a bit next year to be more responsive to

all of the changes coming down the pike for 2021. **And, speaking of those changes, in this edition, we have all the changes for 2020---EXCEPT CPT, which will be in our next newsletter.**

Included in this edition are the following important items:

- The Physician Fee Schedule Final Rule for 2020 which includes
- The Evaluation and Management Guideline Changes for 2021
- The Hospital Outpatient Final Rule for 2020 and
- HCPCS for Drugs 2020

And, here is something amazing--we actually have good news for 2021!!! Read on....

My love all of you,

Da' Mistress

FINAL PHYSICIAN FEE SCHEDULE 2020

The Centers for Medicare & Medicaid Services (CMS) on November 1, 2019, published the Calendar Year (CY) 2020 Final Rule for the Medicare Physician Fee Schedule (MPFS). The MPFS dictates Medicare payment and policies under Part B, while the Quality Payment Program (QPP) continues to tweak two key value-based programs: the Merit-Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

To learn more about the MPFS and QPP Final Rule, here are some resources:

- Final Rule
- CMS Fact Sheet

The Final Rule, along with the new Relative Value Units (RVUs) and payment rates, will go into effect for dates of service on or after January 1, 2020.

Below is a summary of highlights (using the term loosely) of the Final Rule for 2020.

Physician Fee Schedule Conversion Factor: **CMS finalized a CY 2020 conversion factor of $36.0896, a nickel increase above the 2019 MPFS conversion factor of $36.0391**.

Drugs: Because of the plethora of bills in Congress to allegedly lower the price of drugs, there are **no changes in the Final Rule to pricing for drugs, including biosimilar**s.

Telehealth Updates: The overall rules for telehealth did not change--DANG! CMS finalized the proposal to add three new Healthcare Common Procedure Coding System (HCPCS) G codes describing the new bundled treatment of opioid use disorders. Codes G2086 through G2088 represent office-based treatment planning and therapy based on the time length and month of treatment. CMS will offer these services without the usual geographical limitations for telehealth. **CMS also slightly increased the Medicare telehealth originating site fee to $26.65 in 2020, from $26.15 in 2019.**

- G2086: Office-based treatment for opioid use disorder, including the development of the treatment plan, care coordination, individual therapy, and group therapy and counseling; at least 70 minutes in the first calendar month.
- G2087: Office-based treatment for opioid use disorder, including care coordination, individual therapy, and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
- G2088: Office-based treatment for opioid use disorder, including care coordination, individual therapy, and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (list separately in addition to code for primary procedure).

Digital E/M: CMS finalized its policy to create six new non-face-to-face codes to describe and

reimburse for "patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office." The code descriptors refer to "online digital evaluation and management service, for an established patient, for up to seven days, a cumulative time during the seven days" and are reimbursed in increments of 5-10 minutes, 11-20 minutes, and 21 or more minutes.

- **CPT code 98970 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes),**
- **CPT code 98971 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes), and**
- **CPT code 98972 (Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes).**
- **HCPCS code G2061 (Qualified non-physician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days, 5-10 minutes);**
- **HCPCS code G2062 (Qualified non-physician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7days; 11-20 minutes); and**
- **HCPCS code G2063 (Qualified non-physician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minute**

Digital Consent**: In its proposal for 2020, CMS asked for comments on whether a single beneficiary consent can be obtained for certain communication-based technology services (CTBS) designated in the final 2019 MPFS**, including virtual visits (HCPCS 2012), remote evaluation of images (HCPCS 2010), and

Interprofessional Internet Consultations (CPT codes 99446-99449, 99451 and 99452). Based on commenters' positivity, CMS is finalizing a policy to permit a single consent to be obtained for multiple CTBS or interprofessional consultation services. **CMS believes an appropriate interval for the single consent is one year and is finalizing that the single consent must be obtained at least annually.**

Review and Verification of Medical Record Documentation: Because of the "Patients Over Paperwork" initiative (a very good move by your friends in the Federal Government), **CMS finalized modifications to the documentation policy**. Basically, it states certain providers could review and verify (sign and date), rather than reiterating notes made in the medical record by other physicians, residents, nurses, students or other members of the medical team. CMS will allow **the physician, the physician assistant (PA) or the Advanced Practice Registered Nurse (APRN) who furnishes and bills for their professional services to review and verify, rather than re-documen**t. This principle would be applied across all Medicare-covered services paid under the fee schedule. CMS will change regulations for teaching physicians, physicians, PAs and APRNs to add this change in documentation.

Physician Assistants: CMS finalized their proposal to allow supervision of Physician Assistants to be dictated by state law. In the absence of state law, the collaboration between the PA and the physician need not be documented as proposed last summer, but can be attested to once per year.

Care Management: For the past few years, CMS has spearheaded the effort to get providers to coordinate the care of their patients. This year is no exception. Originally, they proposed a boatload of codes for care management that were utterly confusing. They pared it down and here are some

of the changes--**one of which is really cool for Oncology practices and clinics**.

- **CMS finalized its policy to increase payment and unbundle services for Transitional Care Management (TCM).** CMS also revised billing requirements for TCM by allowing TCM codes to be billed concurrently with a list of 14 codes that CMS thinks might complement TCM services rather than substantially overlap or duplicate services. Since we never bill this in Oncology, the unbundling might help you want to bill these, unless you are in the OCM.
- **Principal Care Management (PCM) has been added for care management of a single problem--not 2 or more problems.** Additionally, CMS finalized its policy to create new coding (G2064 and G2065) for Principal Care Management (PCM) services, which would pay clinicians for providing care management for patients *with a single serious and high-risk condition*. CMS is finalizing these two new codes with a higher RVU ($$$$) than proposed, which will result in a slightly higher payment rate. CMS established that PCM services include coordination of medical and/or psychosocial care related to the single complex chronic condition, provided by a physician or clinical staff under the direction of a physician or other qualified healthcare professional. **This is a good deal for non-OCM practices and clinics.**
- **Finally, CMS created a new code for additional time spent beyond the initial 20 minutes allowed in the current coding for chronic care management (CCM) services (G2058)** and established a policy to allow for a single consent per year for communication technology-based services rather than requiring the provider to obtain consent with each interaction. This should be added onto code 99490.

Appropriate Use Criteria (AUC)/Clinical Decision Support (CDS): This was not really covered in the Final Rule. **But, these rules go into effect January 1, 2020 as they have been on the books**

for years. CMS is proposing no changes regarding implementation of the mandate requiring that clinicians consult appropriate use criteria (AUC) through a qualified clinical decision support mechanism (CDSM) starting January 1, 2020, when ordering advanced imaging services (i.e., SPECT/PET MPI, CT and MR). As we previously mentioned, requirements were outlined in a super MLN Matters article. **No claims will be denied for lack of CDSM until 2021.**

Open Payments ("Sunshine Act"):The Open Payments program is a statutorily mandated program that generates information to the public about the financial relationships between the pharmaceutical and medical device industry and certain healthcare providers. CMS finalized several changes to the "Open Payments" program: **1) expanding the definition of "covered recipient" (as required by the SUPPORT for Patients and Communities Act) to Nurse Practitioners, PAs, CRNAs, CNMNs, etc., 2) modifying payment categories to include debt forgiveness, acquisition, long-term supply or device loan and 3) standardizing data on reported medical devices as well as all drugs must be report by NDC (not just drugs used in research).**

Comments on Bundled Payments Under the MPFS: As you know, hospital outpatient payment fee schedule bundles payments to hospitals. All drugs $125 and under per encounter are bundled this year. In the proposed rule, CMS sought public comments on opportunities to expand the concept of bundling to recognize "efficiencies among physicians' services paid under the MPFS" (a euphemism for wanting to cut your money) and "better align" Medicare payment policies. The final rule outlined that comments were received in response to this request. My guess is they decided to shred the ones that told them where they could put this proposal. **CMS may have future**

rulemaking on this topic.

Evaluation and Management (E/M) 2021: CMS finalized its revised approach (from 2019) in terms of billing for evaluation and management (E/M) visit codes. The changes will take effect on January 1, 2021, to allow time for educating over a million providers--a major snooze fest, and to afford the opportunity to alter Electronic Medical Records to facilitate revised documentation guidelines.

The final rule highlights the following E/M changes:

- **retained five levels of coding for established patients;**
- set four levels for office and outpatient E/M visits for new patients, eliminating 99201;
- established **only two permissible criteria for E/M visits**--Medical Decision-making and time, meaning that history and physical will only be counted if medically necessary and that the old criteria, 1997 or 1995 are gone;
- finalized a new Current Procedural Terminology (CPT) code, **99xxx, which describes each 15 minutes of a prolonged E/M office/ outpatient visit that can only be added**
- There will be an add-on code for specialists and primary care, which will pay an an additional $17;
- CMS, however, is not making any changes to the E/M office visits captured in the 10-day and 90-day global codes. CMS plans to continue to assess and develop an approach to revaluing global surgery procedures, including the associated post-operative visits.

These finalized provisions are not just CMS (Medicare and Medicaid)--they coincide with the adoption by CMS of the American Medical Association (AMA) Relative Value Scale Update Committee's (RUC) recommended work RVUs for all of the office/outpatient E/M visit codes and the new extended visit add-on code. The AMA has published their version of the rules here. The RUC-recommended values yield higher work RVUs (mo'

$$$) for most office/outpatient E/M services. **According to the Final Rule, Hem-Onc's will yield a 12% increase from these new changes and that is nothing to sneeze at!!!** BUT, CMS is required to make an annual adjustment to physician payments to maintain budget neutrality, if the changes to the work RVUs result in an increase or decrease in the overall expenditures. Thus, increases in reimbursement for E/M services will result in a positive impact for providers that receive a large part of their revenue from E/M. Whereas for other providers that do not frequently bill E/M codes will receive a negative impact. **And, take my word the procedural docs are all over it as some are taking an 8-10% DECREASE. But, 12% is really cool for us--partly because drug pricing is way up in the air in 2020. We just need to make sure it really happens.**

Medicare Shared Savings Program (MSSP): In the proposed rule, CMS sought public comments on how to potentially align the Medicare Shared Savings Program (MSSP) quality performance scoring methodology more closely with the Merit-Based Incentive Payment System (MIPS) quality performance scoring methodology. In the final rule, CMS notes that it will continue to explore updates and changes to facilitate such alignment.

Changes to Merit-Based Incentive Payment System (MIPS) MIPS Performance Threshold and Incentives: Here are the major changes to MIPS in 2020.

- **CMS finalized its proposal to increase the performance threshold to 45 points for the 2020 performance year/2022 payment year, up from 30 points in 2019**. CMS intends to increase the threshold to 60 points in the 2021 MPFS performance year. The performance threshold is the minimum number of points needed to avoid a negative payment adjustment.
- **CMS also finalized an additional increase**

for exceptional performance to 85 points (up from 80 in the proposed rule) in 2020.The threshold will also remain at 85 points for the 2021 performance year/2023 payment year.

- **Finally, CMS will also move forward with increasing the minimum MIPS penalties and maximum MIPS base incentives from -7 percent/+7 percent in 2019 to -9 percent/+9 percent for 2020**.
- **MIPS Category Weighting:**
  - Quality: As opposed to the Proposed Rule, CMS will maintain the quality performance category at 45 percent for 2020 performance year (no change from 2019). CMS has outlined its plan to lower the weight to 35 percent in 2021 and finally 30 percent in 2022.
    - CMS reinforced guidelines for removing quality measures that do not meet the case minimum and reporting volume required for benchmarking after two consecutive years in the MIPS program.
    - For 2020, **CMS finalized its policy to continue allowing eligible clinicians and groups to submit a single measure via multiple collection types** (e.g., MIPS Clinical Quality Measures (CQM), Electronic Clinical Quality Measures (eCQM), Qualified Clinical Data Registry (QCDR) measures and Medicare Part B claims measures).
  - Cost: CMS will maintain the MIPS' cost performance category at 15 percent (same as 2019)--it was supposed to go to 20%. However, CMS said it "will revisit increasing the weight of the cost performance category in next year's rulemaking to ensure clinicians are prepared for the significant increase in category weight by the 2024 MIPS payment year."
    - CMS will also move forward with the **inclusion of 10 new episode-based** cost measures for implementation in 2020--none of which are Hem-Onc:
      1. Acute Kidney Injury Requiring New Inpatient Dialysis

2. Elective Primary Hip Arthroplasty
3. Femoral or Inguinal Hernia Repair
4. Hemodialysis Access Creation
5. Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
6. Lower Gastrointestinal Hemorrhage
7. Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
8. Lumpectomy Partial Mastectomy, Simple Mastectomy
9. Non-Emergent Coronary Artery Bypass Graft (CABG)
10. Renal or Ureteral Stone Surgical Treatment

- **CMS also finalized changes to both the Medicare Spending Per Beneficiary (MSPB) measure and the Total Per Capita Cost (TPCC) measure. CMS will develop an exclusion list that is considered clinically unrelated to the index admission of the revised MSPB measure (AND, that includes Medical Oncology).** There will also be a change in the attribution methodology to distinguish between medical episodes and surgical episodes. CMS will advance changes to the TPCC measure as well.

- Improvement Activities (IA): **CMS will maintain the performance category at 15 percent (no change from 2019).**
  - CMS also finalized significant changes to IA reporting requirements for group reporters. Previously, groups could report an IA as long as one member of the practice had completed that IA. For 2020, CMS raised that requirement to at least 50% of the group within the same continuous 90-day period.
  - CMS will recognize other Medical Homes other than those they listed in the original MIPS rules.

- Due to the advent of appropriate use criteria (AUC) for diagnostic imaging, CMS will continue offering high-weighted IA credit for those referring physicians who are early adopters by participating in clinical decision support for 2020.
- For the 2020 MIPS performance year, CMS finalized the addition of two new IAs, including a new Drug Cost Transparency IA.

- Promoting Interoperability: **CMS will maintain the performance category at 25 percent (no change from 2019).**
- Facility-Based Scoring: A facility-based group would be defined as one in which 75 percent or more of the MIPS eligible clinicians national provider identifiers (NPIs) billing under the group's taxpayer identification number (TIN) are eligible for facility-based measurement as individuals. There are no submission requirements for individual clinicians in facility-based measurement, but a group must submit data in the Improvement Activities or Promoting Interoperability performance categories to be measured as a group under facility-based measurement.
- Qualified Clinical Data Registry (QCDR): CMS made updates to requirements for QCDR measures and the services that third-party intermediaries must provide (beginning with the 2021 performance period).
- New Pathway for MIPS: **CMS finalized its policy to create the MIPS Value Pathways (MVPs) beginning with the 2021 performance year/2023 payment year**. The agency believes that this pathway will decrease clinician burden and improve the quality of performance data--but, no one really knows what this thing will look like. Ultimately, CMS wants to use this framework so that all MIPS eligible clinicians will have to participate through an MVP or a MIPS APM. But, check it out-- CMS has not yet indicated whether participation is mandatory or not.

As you can see, we are in for some big changes--PARTICULARLY for 2021. I**f you need to schedule a webinar to review these changes**

with your clinicians, please let us know. We are happy to help.

Final Hospital Outpatient Rule 2020

The Centers for Medicare & Medicaid Services (CMS) on July, 2019, published the Calendar Year (CY) 2020 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System FINAL Rule. To find out more about the OPPS and ASC proposals, check out the following resources:

- Final Rule
- CMS Press Release
- CMS Fact Sheet

Below is a summary of the highlights (if you want to call them that) of the Proposed Rule:

- OPPS Payment Updates: **CMS proposed a 2.7 percent increase in the OPPS conversion factor (CF) and it went to 2.6 percent in the Final rule**.
- Payment for 340B Drugs and Biologics: Beginning January 1, 2018, Medicare has paid an adjusted amount of ASP minus 22.5 percent for certain separately payable drugs or biologicals that are acquired through the 340B Program by a hospital paid under the OPPS that is not excepted from the payment adjustment policy. **CMS will continue to pay ASP-22.5 percent for 340B-acquired drugs including to Section 603 Provider-based Departments**. In the proposed rule, CMS discussed the ongoing litigation, which we have covered extensively, relating to ASP-22.5%. The lawsuit continues on and all sides are hopeful that there will be a settlement reached by January 1.
- Supervision of Therapeutic Services: **CMS finalized a change to the minimum required level of supervision for hospital outpatient therapeutic services from direct supervision to general supervision for services furnished by all hospitals and critical access hospitals.** General supervision means that the procedure is provided under the physician's overall

procedure is provided under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.In the proposed rule, **CMS sought public comments on whether specific types of services, such as chemotherapy administration or radiation therapy, should be excepted from the change to the supervision requirements. CMS finalized the proposal to apply to all services, including chemotherapy and radiation therapy services.**

- Drug Bundling: **The drug bundling threshold will go up slightly ($5) to $130/day per CMS calculations.** Drugs with a per encounter cost below the packaging threshold amount are not separately reimbursed unless they have pass-through status. With no pass-through status, they are bundled with reimbursement for an associated procedure code, like drug administration.
- Transparency of Hospital Standard Charges: CMS proposed to implement the Trump Executive Order and further implement the Public Health Service Act requiring that U.S. hospitals annually make public a list of standard charges for items and services. It was scrapped in the Final Rule, but will be the subject of a separate rule.
- **Site Neutral Payments for Hospital Clinic Visits**: As finalized in CY 2019 final rule, **CMS will complete implementation of the two-year phase-in of applying the "Medicare Physician Fee Schedule (MPFS) rate" for the clinic visit service (G0463 - Hospital outpatient clinic visit for assessment and management of a patient) when provided at an off-campus PBD and reimbursed under OPPS**. This clinic visit is the most common service billed under OPPS and typically occurs in the physician office. Last year, it was paid at 70% of the hospital outpatient rate; in 2020, it is proposed at 40%. BUT**, the U.S. District Court for the District of Columbia on September 17, 2019, issued a decision against the CMS "site-neutral" payment policy. Stay tuned...**
- Quality Reporting: For the CY 2020 Hospital

Quality Reporting. For the CY 2020 Hospital Outpatient Quality Reporting (OQR) Program, CMS will remove OP-33: External Beam Radiotherapy for Bone Metastases for the CY 2022 payment determination and subsequent years with modification.

There are lots more parts of this rule that we did not cover including the wage index, the "Inpatient Only changes, Comprehensive APCS, and changes in Organ Procurement. To see all the Final Rule, check it out right here.

New/Sort of New HCPCS for 2020

One thing we expected to see in the FINAL Rule was the revised process for HCPCS code acceptance. Why do some drugs get codes by Quarter and others do not??? I guess we just do not get to know. So, here is the update of the new codes for 2020---some of them should look pretty familiar by now since they came out in July or October.

J0121	ADD	Inj., omadacycline, 1 mg
J0122	ADD	Inj., eravacycline, 1 mg
J0179	ADD	Inj, brolucizumab-dbll, 1 mg
J0222	ADD	Inj., patisiran, 0.1 mg
J0291	ADD	Inj., plazomicin, 5 mg
J0593	ADD	Inj., lanadelumab-flyo, 1 mg
J0642	ADD	Injection, khapzory, 0.5 mg
J1096	ADD	Dexametha opth insert 0.1 mg
J1097	ADD	Phenylep ketorolac opth soln
J1303	ADD	Inj., ravulizumab-cwvz 10 mg
J1444	ADD	Fe pyro cit pow 0.1 mg iron
J1943	ADD	Inj., aristada initio, 1 mg
J1944	ADD	Aripirazole lauroxil 1 mg
J2798	ADD	Inj., perseris, 0.5 mg
J3031	ADD	Inj., fremanezumab-vfrm 1 mg

J3111	ADD	Inj. romosozumab-aqqg 1 mg
J7208	ADD	Inj. jivi 1 iu
J7314	ADD	Inj., yutiq, 0.01 mg
J7331	ADD	Synojoynt, inj., 1 mg
J7332	ADD	Inj., triluron, 1 mg
J7401	ADD	Mometasone furoate sinus imp
J7677	ADD	Revefenacin inh non-com 1mcg
J9030	ADD	Bcg live intravesical 1mg
J9036	ADD	Inj. belrapzo/bendamustine
J9118	ADD	Inj. calaspargase pegol-mknl
J9119	ADD	Inj., cemiplimab-rwlc, 1 mg
J9199	ADD	Injection, infugem, 200 mg
J9204	ADD	Inj mogamulizumab-kpkc, 1 mg
J9210	ADD	Inj., emapalumab-lzsg, 1 mg
J9269	ADD	Inj. tagraxofusp-erzs 10 mcg
J9309	ADD	Inj, polatuzumab vedotin 1mg
J9313	ADD	Inj., lumoxiti, 0.01 mg
J9356	ADD	Inj. herceptin hylecta, 10mg
Q5112	ADD	Inj ontruzant 10 mg
Q5113	ADD	Inj herzuma 10 mg
Q5114	ADD	Inj ogivri 10 mg
Q5115	ADD	Inj truxima 10 mg
Q5116	ADD	Inj., trazimera, 10 mg
Q5117	ADD	Inj., kanjinti, 10 mg
Q5118	ADD	Inj., zirabev, 10 mg

For more information regarding deleted codes and changed codes, please see the HCPCS table right here...

Remember this newsletter is a summary of regulations for Medical Oncology. It is a preliminary reading of complex coding and billing material. There may be typos and misinterpretations. Providers are responsible for the information on every claim. Payers have differing rules and interpretations thereof. Reading this newsletter does not substitute for understanding regulations and verifying the validity of every claim. This information is time-sensitive and is subject to constant change.

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Sincerely,

Da' Mistress of All She Surveys

Sincerely,

Roberta Buell
onPoint Oncology LLC