Hot Topics In Reimbursement 2020

Bobbi Buell MBA
800-795-2633
bbuell@onpointoncology.com
Bobbibuell1@yahoo.com
NEWSLETTER: www.onpointoncology.com

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AGENDA

- Final Physician Fee Schedule Rule for 2020
- Final Changes to MIPS
- Final Hospital Outpatient Payment Program Rule 2020
- Coding Changes
- Appendices

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Web Sites for 2020 Final Regulations

- This presentation is based on published rules
  - The Final Rules were published on November 1, 2019
  - The Comment Period is until 12/31/2019 for E/M only
- Physician Rule: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.html
- Hospital Outpatient Rule: https://www.federalregister.gov/documents/2019/11/12/2019-24138/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center.

Medicare Physician Payment Basics

- Payments are based on RVUs for each code (WRVUs+PERVUs+MalRVUs)
- RVUs are multiplied times GPCIs for your geographical location (W*WGPCI+PE*PEGPCI+Mal*MalGPCI)
- The Medicare conversion factor determines the overall level of Medicare payments (W*WGPCI+PE*PEGPCI+Mal*MalGPCI) times CF = $Your Total Allowable for your area, which will be inflated, deflated, or neutralized by your QPP performance.

W = Work; PE = Practice Expense; MAL = Expense of Malpractice; RVUs = relative value units

Fee Schedule: Does Not Include Sequestration

- Sequestration:
  - Medicare 2% across the board started on April 1, 2013
  - Impacts everything including drugs
  - The 2% comes out of the Medicare portion (80%)
    - Drugs are paid at 104.304% ASP
    - All patient payments excluded
- Murray-Ryan Budget Deal extended the Sequester until 2023; PAMA extended it to 2024, and another bill extended it to 2025.

For more about sequestration:https://www.nejm.org/doi/full/10.1056/NEJMp1303266?query=TOC&goback=.gde_917937_member_224781137&page=-33&sort=oldest

CONVERSION FACTOR Final for 2020

TABLE 117: Calculation of the CY 2020 PFS Conversion Factor

CY 2019 Conversion Factor		36.0391
Statutory Update Factor	0.00 percent (1.0000)	
CY 2020 RVU Budget Neutrality Adjustment	0.14 percent (1.0014)	
CY 2020 Conversion Factor		**36.0896**

Source: PHYSICIAN Fee Schedule Final Rule 2019, Table 117, Page 1893

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Table 119: Final Fee Schedule, Page 1894

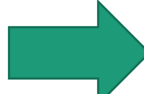

TABLE 119: CY 2020 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$237	0%	0%	0%	0%
Anesthesiology	$2,002	0%	0%	0%	0%
Audiologist	$71	0%	1%	0%	1%
Cardiac Surgery	$281	-1%	-1%	0%	-2%
Cardiology	$6,618	0%	0%	0%	0%
Chiropractor	$756	0%	0%	-1%	-1%
Clinical Psychologist	$793	1%	2%	0%	3%
Clinical Social Worker	$787	0%	3%	0%	4%
Colon And Rectal Surgery	$163	0%	1%	0%	1%
Critical Care	$349	0%	0%	0%	0%
Dermatology	$3,550	0%	1%	-1%	0%
Diagnostic Testing Facility	$703	0%	-3%	0%	-3%
Emergency Medicine	$3,035	1%	0%	1%	1%
Endocrinology	$490	0%	0%	0%	0%
Family Practice	$6,056	0%	0%	0%	0%
Gastroenterology	$1,721	0%	0%	-1%	0%
General Practice	$410	0%	0%	0%	0%
General Surgery	$2,047	0%	0%	0%	0%
Geriatrics	$188	0%	0%	0%	0%
Hand Surgery	$226	0%	1%	0%	1%
Hematology/Oncology	$1,678	0%	0%	0%	0%
Independent Laboratory	$597	0%	1%	0%	1%
Infectious Disease	$643	0%	0%	0%	0%
Internal Medicine	$10,581	0%	0%	0%	0%
Interventional Pain Mgmt	$890	0%	1%	0%	1%
Interventional Radiology	$434	0%	-2%	0%	-1%
Multispecialty Clinic/Other Phys	$149	0%	0%	0%	0%
Nephrology	$2,176	0%	0%	0%	0%
Neurology	$1,512	-1%	-1%	0%	-2%
Neurosurgery	$807	0%	0%	-1%	0%
Nuclear Medicine	$50	0%	1%	0%	1%
Nurse Anes / Anes Asst	$1,297	0%	0%	0%	0%
Nurse Practitioner	$4,532	0%	0%	0%	0%
Obstetrics/Gynecology	$624	0%	1%	0%	1%
Ophthalmology	$5,413	-2%	-2%	0%	-4%
Optometry	$1,335	0%	-1%	0%	-2%
Oral/Maxillofacial Surgery	$72	0%	0%	-1%	-1%
Orthopedic Surgery	$3,750	0%	1%	0%	1%
Other	$35	0%	0%	0%	0%
Otolaryngology	$1,230	0%	0%	0%	0%
Pathology	$1,212	0%	0%	0%	0%
Pediatrics	$64	0%	0%	0%	0%
Physical Medicine	$1,117	0%	0%	0%	1%
Physical/Occupational Therapy	$4,273	0%	0%	0%	0%
Physician Assistant	$2,650	0%	0%	0%	0%
Plastic Surgery	$373	0%	0%	0%	0%
Podiatry	$2,017	0%	1%	0%	2%

Part B Physician Drug Changes 2020--Final

Part B Physician Drug Changes 2020--Final

- No substantial changes as part of this Final Rule
- No word on new HCPCS Process
- Something may be coming from CMMI in terms of the next Part B Experiment

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Appropriate Use Criteria for Advanced Imaging

- In the 2019 Final and Final rule, CMS reaffirmed the January 1, 2020 mandatory consultation date with a one-year education and operations testing period. This has been in the regulations for 5 years. This was not covered in this year's Final RULE, so it may be subject to change in the FINAL RULE.

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Appropriate Use Criteria

- Advanced diagnostic imaging services includes:
  - Services defined in Section 1834(e)(1)(B) of the Social Security Act (the Act) Diagnostic magnetic resonance imaging, computed tomography, and nuclear medicine (including positron emission tomography)
  - AUC is criteria only developed or endorsed by national professional medical specialty societies or other provider-led entities (PLEs), so ordering and furnishing professionals can make the most patient-appropriate treatment decision for the specific clinical condition.
  - To the extent possible, criteria must be evidence based. A CDSM is an interactive, electronic tool for clinicians that gives the user AUC information.
  - An ordering professional is a physician (as defined in Section 1861(r) of the Act) or a practitioner described in Section 1842(b)(18)(C) of the Act who orders an applicable imaging service.
  - Priority clinical areas are clinical conditions, diseases, or symptom complexes and associated imaging services CMS identifies through annual rulemaking and in consultation with stakeholders. These areas may be used in the determination of outlier ordering professionals..

QUALIFIED PROVIDER LED ENTITIES (“PLEs”)

- **Qualified PLEs as of June 2019**
  - American College of Cardiology Foundation
    American College of Radiology
    Banner University Medical Group-Tucson University of Arizona
    CDI Quality Institute
    Cedars-Sinai Health System
    High Value Practice Academic Alliance
    Intermountain Healthcare
    Johns Hopkins University School of Medicine*
    Massachusetts General Hospital, Department of Radiology
    Medical Guidelines Institute
    Memorial Sloan Kettering Cancer Center
    National Comprehensive Cancer Network
    Sage Evidence-based Medicine & Practice Institute
    Society for Nuclear Medicine and Molecular Imaging
    Synergetic Professional Guidelines Institute*
    University of California Medical Campuses
    University of Pennsylvania Health System
    University of Texas MD Anderson Cancer Center
    University of Utah Health
    University of Washington School of Medicine
    Virginia Mason Medical Center
    Weill Cornell Medicine Physicians Organization

Appropriate Use Criteria Timeline

- Currently, the program is set to be fully implemented on January 1, 2021 which means AUC consultations with qualified CDSMs are required to occur along with reporting of consultation information on the furnishing professional and furnishing facility claim for the advanced diagnostic imaging service.
- Prior to this date the program will operate in an Education and Operations Testing Period starting January 1, 2020 during which claims will not be denied for failing to include proper AUC consultation information.
- Claims that fail to append this information will not be paid after 1/1/21. .
- Beginning July 1, 2018 the program is operating under a voluntary participation period during which time consultations with AUC may occur and may be reported on furnishing professional and facility claims using HCPCS modifier QQ. See the HCPCS slides herein for newer modifiers and
- See this great Medlearn Matters for all the information you need to report for AUC: https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11268.pdf

https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/appropriate-use-criteria-program/index.html

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Appropriate Use Criteria (Cont'd)

- Priority Clinical Areas In establishing priority clinical areas, CMS considers how common and widespread a condition, disease, or symptom complex is, the variation of image ordering, and the strength of evidence supporting particular imaging services. CMS also considers the relevance to the Medicare population. CMS identified the following eight priority areas that may be used in the determination of outlier ordering professionals in the future:
  - Coronary artery disease (suspected or diagnosed)
  - Suspected pulmonary embolism
  - Headache (traumatic and non-traumatic)
  - Hip pain
  - Low back pain
  - Shoulder pain (to include suspected rotator cuff injury)
  - ***Cancer of the lung (primary or metastatic, suspected or diagnosed)***
  - Cervical or neck pain
  - The list may be updated and can be found on the Priority Clinical Areas webpage.
- Upon full program implementation, please note that AUC consultation is required for all advanced diagnostic imaging services, not just those within the priority clinical areas.

https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/appropriate-use-criteria-program/index.html

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Appropriate Use Criteria (Cont'd)

- Beginning January 1, 2020, you must use a qualified CDSM and report AUC consultation information on the professional and facility claims for the service—but, as previously stated, claims will not be denied.
  - Specific claims processing instructions will be issued closer to 2020. Claims for advanced diagnostic imaging services will include information on:
    - The ordering professional's NPI
    - Which CDSM was consulted (there are multiple qualified CDSMs available)
    - Whether the service ordered would or would not adhere to consulted AUC or whether consulted AUC was not applicable to the service ordered
    - As the ordering professional, they may delegate the AUC consultation to clinical staff acting under their direction if they do not personally perform the AUC consultation yourself..

https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/appropriate-use-criteria-program/index.html

AUC MODIFIERS

- MA - Ordering professional is not required to consult a clinical decision support mechanism due to service being rendered to a patient with a suspected or confirmed emergency medical condition
- MB - Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of insufficient internet access
- MC - Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of electronic health record or clinical decision support mechanism vendor issues
- MD - Ordering professional is not required to consult a clinical decision support mechanism due to the significant hardship exception of extreme and uncontrollable circumstances
- ME - The order for this service adheres to the appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
- MF - The order for this service does not adhere to the appropriate use criteria in the qualified clinical decision support mechanism consulted by the ordering professional
- MG - The order for this service does not have appropriate use criteria in the clinical decision support mechanism consulted by the ordering professional
- MH - Unknown if ordering professional consulted a clinical decision support mechanism for this service, related information was not provided to the furnishing professional or provider
- QQ - Ordering professional consulted a qualified clinical decision support mechanism for this service and the related data was provided to the furnishing professional (effective date: 7/1/18)

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Appropriate Use Vendors June 2019

Qualified Clinical Decision Support Mechanisms as of June 2019

AgileMD's Clinical Decision Support Mechanism
AIM Specialty Health ProviderPortal®*
Applied Pathways CURION™ Platform
Cranberry Peak ezCDS
eviCore healthcare's Clinical Decision Support Mechanism
EvidenceCare's Imaging Advisor
Inveni-QA's Semantic Answers in Medicine™
MedCurrent OrderWiseTM
Medicalis Clinical Decision Support Mechanism
National Decision Support Company CareSelect™*
National Imaging Associates RadMD
Reliant Medical Group CDSM
Sage Health Management Solutions Inc. RadWise®
Stanson Health's Stanson CDS
Test Appropriate CDSM*

Clinical Decision Support Mechanisms with Preliminary Qualification as of June 2019

Cerner CDS mechanism
Evinance Decision Support
Flying Aces Speed of Care Decision Support
HealthHelp's Clinical Decision Support Mechanism
Infinx CDSM
LogicNets' Decision Engines
New Century Health's CarePro

*Free Tool Available

https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/appropriate-use-criteria-program/index.html

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AUC HCPCS Codes

- G1000 - Clinical Decision Support Mechanism Applied Pathways, as defined by the Medicare Appropriate Use Criteria Program
- G1001 - Clinical Decision Support Mechanism eviCore, as defined by the Medicare Appropriate Use Criteria Program
- G1002 - Clinical Decision Support Mechanism MedCurrent, as defined by the Medicare Appropriate Use Criteria Program
- G1003 - Clinical Decision Support Mechanism Medicalis, as defined by the Medicare Appropriate Use Criteria Program
- G1004 - Clinical Decision Support Mechanism National Decision Support Company, as defined by the Medicare Appropriate Use Criteria Program
- G1005 - Clinical Decision Support Mechanism National Imaging Associates, as defined by the Medicare Appropriate Use Criteria Program
- G1006 - Clinical Decision Support Mechanism Test Appropriate, as defined by the Medicare Appropriate Use Criteria Program
- G1007 - Clinical Decision Support Mechanism AIM Specialty Health, as defined by the Medicare Appropriate Use Criteria Program
- G1008 - Clinical Decision Support Mechanism Cranberry Peak, as defined by the Medicare Appropriate Use Criteria Program
- G1009 - Clinical Decision Support Mechanism Sage Health Management Solutions, as defined by the Medicare Appropriate Use Criteria Program
- G1010 - Clinical Decision Support Mechanism Stanson, as defined by the Medicare Appropriate Use Criteria Program
- G1011 - Clinical Decision Support Mechanism, qualified tool not otherwise specified, as defined by the Medicare Appropriate Use Criteria Program

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Appropriate Use Criteria (Cont’d)

- CMS may make the following AUC reporting requirements exceptions for:
  - Emergency services, when provided to patients with certain emergency medical conditions (as defined in Section 1867(e)(1) of the Act)
  - Inpatients and for which Medicare Part A payment is made
  - Ordering professionals, when experiencing a significant hardship including: Insufficient internet access EHR or CDSM vendor issues Extreme and uncontrollable circumstances
- If you become an outlier in terms of AUC implementation, you may be subject to prior authorization.

https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/appropriate-use-criteria-program/index.html

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Telehealth Services—Additions for 2020--Final

- Overall, CMS Rules are not changing, EXCEPT for Medicare Advantage, which will be discussed later.
- Medicare proposes to add three codes for new services. They are proposing to add the face-to-face portions of the following services to the telehealth list on a Category 1 basis for CY 2020:
  - HCPCS code G2086: Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month
  - HCPCS code 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.
  - HCPCS code 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).

Page 186, Display Copy, Final Rule

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Final Review of Documentation in the Medical Record

- CMS proposes to establish a general principle to allow the physician, the PA, or the APRN who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by trainees such as physicians, residents, nurses, students or other members of the medical team. This principle would apply across the spectrum of all Medicare-covered services paid under the PFS
- When furnishing their professional services, the clinician may review and verify (sign/date) notes in a patient's medical record made by other trainees such as physicians, residents, nurses, students, or other members of the medical team, including notes documenting the practitioner's presence and participation in the services, rather than fully re-documenting the information.
- This does not modify the scope of, or standards for, the documentation that is needed in the medical record to demonstrate medical necessity of services, or otherwise for purposes of appropriate medical recordkeeping.

Final Rule Display Copy, Page 367-368

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Final Review of Physician Assistants—Final Rule

- That a PA must furnish their professional services in accordance with state law and state scope of practice rules for PAs in the state in which the PA's professional services are furnished. Any state laws or state scope of practice rules that describe the required practice relationship between physicians and PAs, including explicit supervisory or collaborative practice requirements, describe a form of supervision for purposes of section 1861(s)(2)(K)(i) of the Act.
- For states with no explicit state law or scope of practice rules regarding physician supervision of PA services, physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services .Such physician supervision is evidenced by documenting at the practice level the PA's scope of practice and the working relationships the PA has with the supervising physician/s when furnishing professional services.

Final Rule Display Copy, Page 367-368

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BUNDLED PAYMENTS????

- CMS is not proposing bundled payments for 2020. But, they solicited comments on this proposal.
- See Hospital Outpatient for details on Bundled Payments…but, message to the Wise---they are coming to Physician Payment.

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CMS Statement on Care Management

- "Based on our review of the Medicare claims data we estimate that approximately 3 million unique beneficiaries (9 percent of the Medicare fee-for-service (FFS) population) receive these services annually, with higher use of chronic care management (CCM), transitional care management (TCM), and advance care planning (ACP) services. We believe gaps remain in coding and payment, such as for care management of patients having a single, serious, or complex chronic condition. In this Final rule, we continue our ongoing work in this area through code set refinement related to TCM services and CCM services, in addition to proposing new coding for principal care management (PCM) services, and addressing chronic care remote physiologic monitoring (RPM) services."

Final Rule, Display Copy Page 390

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TABLE 21: Chronic Care Management Codes (CY 2019)

CPT Code	Summary
99490 ("Non-Complex CCM")	Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional (QHP), per calendar month
99491 ("Non-Complex CCM")	Chronic care management services, provided personally by a physician or other QHP, at least 30 minutes of physician or other QHP time, per calendar month
99487 ("Complex CCM")	Complex chronic care management services, first 60 minutes of clinical staff time with moderate or high complexity medical decision making by the reporting practitioner
99489 ("Complex CCM")	Complex chronic care management services, each additional 30 minutes of clinical staff time with moderate or high complexity medical decision making by the reporting practitioner

Page 396, Display Copy, Final Rule

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Components of Chronic Care Management

TABLE 22: Chronic Care Management Services Summary

CCM Service Summary*
Verbal Consent • Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance). • Document that consent was obtained.
Initiating Visit for New Patients (separately paid)
Certified Electronic Health Record (EHR) Use • Structured Recording of Core Patient Information Using Certified EHR (demographics, problem list, medications, allergies).
24/7 Access ("On Call" Service)
Designated Care Team Member
Comprehensive Care Management • Systematic needs assessment (medical and psychosocial). • Ensure receipt of preventive services. • Medication reconciliation, management and oversight of self-management.
Comprehensive Electronic Care Plan • Plan is available timely within and outside the practice (can include fax). • Copy of care plan to patient/caregiver (format not prescribed). • Establish, implement, revise or monitor the plan.
Management of Care Transitions/Referrals (e.g., discharges, ED visit follow up, referrals). • Create/exchange continuity of care document(s) timely (format not prescribed).
Home- and Community-Based Care Coordination • Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits.
Enhanced Communication Opportunities • Offer asynchronous non-face-to-face methods other than telephone, such as secure email.

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of CCM.

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Components of Chronic CARE PLAN per CMS--Revised

- Problem list.
- Expected outcome and prognosis.
- Measurable treatment goals.
- Cognitive and functional assessment.
- Symptom management
- Planned interventions.
- Medical management.
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers.
- Requirements for periodic review.
- When applicable, revision of the care plan."

We anticipate that this change will reduce burden and simplify the important work of interacting and coordinating with resources external to the practice.

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Changes to Transitional Care Management Final for 2020

- Bad news: There are now 57 HCPCS codes that cannot be billed during the 30-day period covered by TCM services by the same practitioner reporting TCM (77 FR 68990).
- CMS is proposing to unbundle these codes in 2020:
- You may also bill 99490-99491 with these codes (Page 396)

TABLE 20: 14 HCPCS Codes that Currently Cannot be Billed Concurrently with TCM by the Same Practitioner and are Active Codes Payable by Medicare PFS

Code Family	HCPCS Code	Descriptor
Prolonged Services without Direct Patient Contact	99358	Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service
	99359	Prolonged E/M service before and/or after direct patient care; each additional 30 minutes beyond the first hour of prolonged services
Home and Outpatient International Normalized Ratio (INR) Monitoring Services	93792	Patient/caregiver training for initiation of home INR monitoring
	93793	Anticoagulant management for a patient taking warfarin; includes review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment and scheduling of additional test(s)
End Stage Renal Disease Services (patients who are 20+ years)	90960	ESRD related services monthly with 4 or more face-to-face visits per month; for patients 20 years and older
	90961	ESRD related services monthly with 2-3 face-to-face visits per month; for patients 20 years and older
	90962	ESRD related services with 1 face-to-face visit per month; for patients 20 years and older
	90966	ESRD related services for home dialysis per full month; for patients 20 years and older
	90970	ESRD related services for dialysis less than a full month of service; per day; for patient 20 years and older
*Analysis of Data	99091	Collection and interpretation of physiologic data
Complex Chronic Care Management Services	99487	Complex Chronic Care with 60 minutes of clinical staff time per calendar month
	99489	Complex Chronic Care; additional 30 minutes of clinical staff time per month
Care Plan Oversight Services	G0181	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities within a calendar month; 30+ minutes
	G0182	Physician supervision of a patient receiving Medicare-covered hospice services (Pt not present) requiring complex and multidisciplinary care modalities; within a calendar month; 30+ minutes

* In CY 2018, this code was unbundled and added as an active code to the PFS. The 2019 CPT Manual (p. 42) indicates the code cannot be billed concurrently with either TCM code.

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Chronic Care Management Final for 2020—Less Complex CCM

- These codes are Final to give staff a way to bill in time increments and these will be used instead of 99490:
  - ~~GCCC1 (Chronic care management services, initial 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; and comprehensive care plan established, implemented, revised, or monitored. (Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately)). CMS proposes a work RVU of 0.61.~~
- G2058 (Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).(Use G2058 in conjunction with 99490). (Do not report G2058 in conjunction with 99491). HCPCS code
- G2058 will be reportable a maximum of two times within a given service period for a given beneficiary. Final work RVU is 0.54

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Complex Chronic Care Management Without Changes to the Care Plan Final—Use Instead of 99487, 99489 (Not Adopted)

- ~~GCCC3 (Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month. (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately)). Final work RVU of 1.00 for HCPCS code GCCC3, which is a crosswalk to CPT code 99487.~~
- ~~GCCC4 (each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure).(Report GCCC4 in conjunction with GCCC3). (Do not report GCCC4 for care management services of less than 30 minutes additional to GCCC3. CMS is proposing a work RVU of 0.50 for HCPCS code GCCC4, which is a crosswalk to CPT code 99489~~.

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Principal Care Management Final 2020

- More than one specialist may bill this. Here's what the Final Rule says: "We anticipate that many patients will have more than one complex chronic condition. If a clinician is providing PCM services for one complex chronic condition, management of the patient's other conditions would continue to be managed by the primary care practitioner while the patient is receiving PCM services for a single complex condition. It is also possible that the patient could receive PCM services from more than one clinician if the patient experiences an exacerbation of more than one complex chronic condition simultaneously."
- BUT, patient is expected to go back to the Primary Care Physician
- Must have the patient's VERBAL consent for cost sharing.

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Principal Care Management: A Single Problem

- "PCM" services would be billed when a single condition is of such complexity that it could not be managed as effectively in the primary care setting, and instead requires management by another, more specialized, practitioner. These are the codes:
  - G2064 (Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of **physician or other qualified health care** professional time per calendar month with the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities). Work RVU = 1.28
  - G2065 (Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of **clinical staff time** directed by a physician or other qualified health care professional, per calendar month with the following elements: one complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities). Work RVU = 0.61

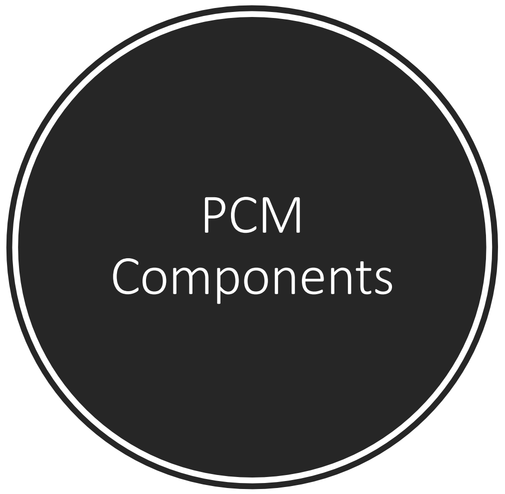

TABLE 24: Principal Care Management Services Summary

PCM Service Summary*
Verbal Consent • Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance). • Document that consent was obtained.
Initiating Visit for New Patients (separately paid)
Certified Electronic Health Record (EHR) Use • Structured Recording of Core Patient Information Using EHR (demographics, problem list, medications, allergies).
24/7 Access ("On Call" Service)
Designated Care Team Member
Disease Specific Care Management Disease Specific Care Management may include, as applicable: • Systematic needs assessment (medical and psychosocial). • Ensure receipt of preventive services. • Medication reconciliation, management and oversight of self-management.
Disease Specific Electronic Care Plan • Plan is available timely within and outside the practice (can include fax). • Copy of care plan to patient/caregiver (format not prescribed). • Establish, implement, revise or monitor the plan.
Management of Care Transitions/Referrals (e.g., discharges, ED visit follow up, referrals, as applicable). • Create/exchange continuity of care document(s) timely (format not prescribed).
Home- and Community-Based Care Coordination • Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits, as applicable.
Enhanced Communication Opportunities • Offer asynchronous non-face-to-face methods other than telephone, such as secure email.

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of PCM.

More Digital Visit Coding

- CMS is proposing 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.” These CPT Codes can be billed by qualified Clinicians—but, currently have no RVUs and cannot be billed to Medicare
  - 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).

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More Digital Visit Coding Allowed by CMS (Cont'd)

- CPT codes 99421-99423 are for practitioners who can independently bill E/M services while CPT codes 98970-98972 are for practitioners who cannot independently bill E/M services
- Some of the CPT codes of digital visits are outside the scope of the CMS definition of folks who are able to bill for E/M services. So, they developed these G-codes in the 2020 proposal which was finalized:
  - 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 minutes).

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Consent for Communication Technology-Based Services (CTBS)

- "We appreciate commenters' support for allowing a single consent to be obtained for multiple CTBS or inter-professional consultation services over an interval of time, rather than requiring consent to be obtained prior to each service. Given the commenters' support, we are finalizing a policy to permit a single consent to be obtained for multiple CTBS or inter-professional consultation services. Based on feedback from commenters, we believe an appropriate interval for the single consent is one year, and we are finalizing that the single consent must be obtained at least annually. We will continue to consider whether a separate consent should be obtained for services that involve direct interaction between the patient and practitioner, and those that do not involve interaction such as inter-professional services; and we may address this issue in potential future rulemaking."

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REMOTE PHYSIOLOGICAL MONITORING 2020

- The new code structure retains CPT code 99457 as a base code that describes the first 20 minutes of the treatment management services, and uses a new add-on code to describe subsequent 20 minute intervals of the service. The new code descriptors for CY 2020 are:
  - CPT code 99457 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial20 minutes) and
  - CPT code 99458 (Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes).
- Not well defined as to what these are…

A Brief Word About Future E/M Services

GET YOUR PROVIDERS TO LEARN TO DOCUMENT TIME!!!!!!

E/M Changes for 2021:

- Effective January 1, 2021, the CPT Editorial Panel has adopted revisions to the office/outpatient E/M code descriptors, and substantially revised both the CPT prefatory language and the CPT interpretive guidelines that instruct practitioners on how to bill these codes. This approach is detailed in full on the AMA website at https://www.ama-assn.org/cpt-evaluation-and-management.
- This is an interim Final Rule with Comment Period until 12/31/2019

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E/M Changes for 2021:

- CMS will assign separate payment rather than a blended rate, to each of the office/outpatient E/M visit codes (except CPT code 99201, which CPT is deleting) and the new prolonged visit add-on CPT code (CPT code 99XXX).
- CMS has deleted the HCPCS add-on code they finalized last year for CY 2021 for extended visits (GPRO1).
- CMS will simplify, consolidate and revalue the HCPCS add-on codes they finalized last year for CY 2021 for primary care (GPC1X) and non-procedural specialized medical care (GCG0X), and to allow the new code to be reported with all office/outpatient E/M visit levels (not just levels 2 through 4). All of these changes will be effective January 1, 2021

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E/M Framework for 2021: Final

- Under this new framework, history and exam would no longer select the level of code selection for office/outpatient E/M visits.
  - **Instead, an office/outpatient E/M visit would include a medically appropriate history and exam, when performed.**
  - **The clinically outdated system for number of body systems/areas reviewed and examined under history and exam would no longer apply, and these components would only be performed when, and to the extent medically necessary and clinically appropriate.**
  - **1995 and 1997 criteria will be deleted 1/1/2021.**
- Level 1 visits would only describe or include visits performed by clinical staff for established patients. And, 99201 would again be deleted.
- For levels 2 through 5 office/outpatient E/M visits, the code level reported would be decided based on either the level of MDM (as redefined in the new AMA/CPT guidance framework) or the total time personally spent by the reporting practitioner on the day of the visit(including face-to-face and non-face-to-face time).

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So What Is The E/M Criteria?

- Instructions for Selecting a Level of Office or Other Outpatient E/M Service Select the appropriate level of E/M services based on the following:
  - 1. The level of the medical decision making as defined for each service; or
  - 2. The total time for E/M services performed on the date of the encounter.
    - Revised CPT will show time in time ranges rather than just one single time for each level of E/M.

https://www.ama-assn.org/system/files/2019-06/cpt-office-prolonged-svs-code-changes.pdf

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Medical Decision-Making

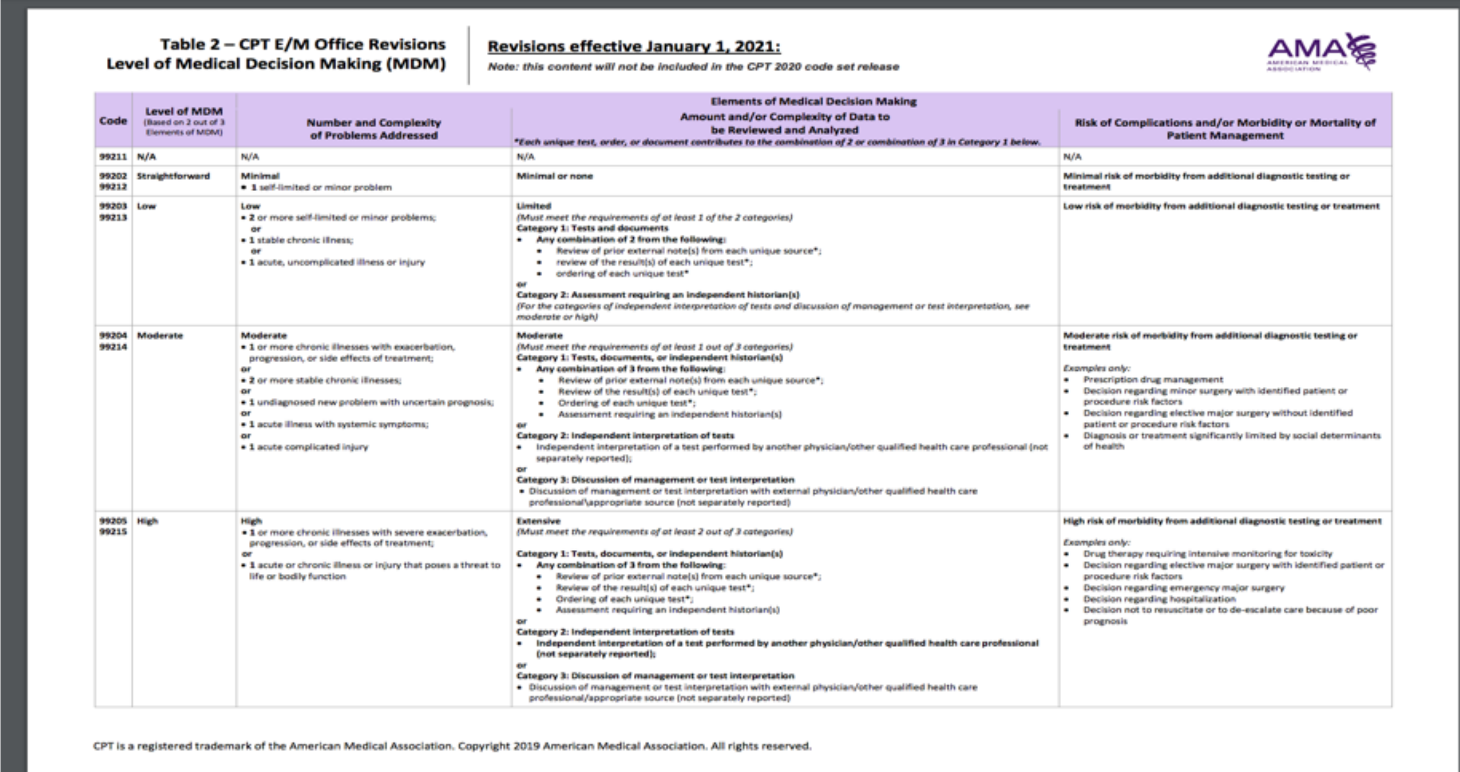

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:
Note: this content will not be included in the CPT 2020 code set release

AMA AMERICAN MEDICAL ASSOCIATION

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Number and Complexity of Problems Addressed	Elements of Medical Decision Making Amount and/or Complexity of Data to be Reviewed and Analyzed *Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • **1** self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• **2** or more self-limited or minor problems;
		or
		• **1** stable chronic illness;
		or
		• **1** acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • review of the result(s) of each unique test*;
			  • ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• **1** or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• **2** or more stable chronic illnesses;
		or
		• **1** undiagnosed new problem with uncertain prognosis;
		or
		• **1** acute illness with systemic symptoms;
		or
		• **1** acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional\appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• **1** or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• **1** acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  • Review of prior external note(s) from each unique source*;
			  • Review of the result(s) of each unique test*;
			  • Ordering of each unique test*;
			  • Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

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Time: A New Definition (2021)

- The time refers to the total visit time on the date of service.
- Extended visit codes CANNOT be attached to any codes except Level 5
    - the revised CPT prefatory language and reporting instructions to mean that there would be a single add-on CPT code for prolonged office/outpatient E/M visits (CPT code 99XXX (Prolonged office or other outpatient evaluation and management service(s)(beyond the total time of the primary procedure which has been selected using total time),requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)) that would only be reported when time is used for code level selection and the time for a level 5 office/outpatient visit (the floor of the level 5 time range) is exceeded by 15 minutes or more on the date of service.
- Non-FTF Prolonged Services (99358-99359) cannot be billed with 99201-99215.

E/M Proposal for 2021: Extended Visits

- GPRO1, the old extended visit add-on will not be used.
- 99XXX is Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services). The time frame for this code is 3 days before and 7 days after FTF. The chart herein shows how prolonged office/outpatient E/M visit time would be reported:

TABLE 26: Total Proposed Practitioner Times for Office/Outpatient E/M Visits When Time Is Used to Select Visit Level

Established Patient Office/Outpatient E/M Visit (Total Practitioner Time, When Time is Used to Select Code Level)	CPT code
40–54 minutes	99215
55-69 minutes	99215x1 and 99XXXx1
70-84 minutes	99215x1 and 99XXXx2
85 or more minutes	99215x1 and 99XXXx3 or more for each additional 15 minutes
New Patient Office/Outpatient E/M Visit (Total Practitioner Time, When Time is Used to Select Code Level)	**CPT code**
60-74 minutes	99205
75-89 minutes	99205x1 and 99XXXx1
90-104 minutes	99205x1 and 99XXXx2
105 or more minutes	99205x1 and 99XXXx3 or more for each additional 15 minutes

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The Add-On Code: Final for 2021

- CMS finalized a new prolonged services code for additional time spent with patients beyond the level 5 visit. They are proposing a payment rate of approximately $35.
- They are also proposing to consolidate the two add-on HCPCS G codes we finalized last year for primary care and certain non-procedural specialty care into a single code describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. The Final payment rate for this services is approximately $17.

TABLE 28: Proposed Revaluation of HCPCS Add-on G code Finalized for CY 2021

HCPCS Code	Proposed Code Descriptor Revisions	FR 2019 total time (mins)	FR 2019 Work RVU	Proposed total time (mins)	Proposed Work RVU
GPC1X	*Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established)*	8.25	0.25	11	0.33

Actual 2020 Work Relative Values from CMS

Code	2019	2021
99202	.93	.93
99203	1.42	1.6
99204	2.43	2.6
99205	3.17	3.5
99211	.18	.18
99212	.48	.7
99213	.97	1.3
99214	1.5	1.92
99215	2.11	2.8

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TABLE 120: Estimated Specialty Level Impacts of Finalized E/M Payment and Coding Policies

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact*
Allergy/Immunology	$236	4%	3%	0%	7%
Anesthesiology	$1,993	-5%	-1%	0%	-7%
Audiologist	$70	-4%	-2%	0%	-6%
Cardiac Surgery	$279	-5%	-2%	-1%	-8%
Cardiology	$6,595	2%	1%	0%	3%
Chiropractor	$750	-5%	-3%	-1%	-9%
Clinical Psychologist	$787	-7%	0%	0%	-7%
Clinical Social Worker	$781	-7%	0%	0%	-6%
Colon And Rectal Surgery	$162	-3%	-1%	-1%	-4%
Critical Care	$346	-5%	-1%	0%	-6%
Dermatology	$3,541	0%	1%	-1%	-1%
Diagnostic Testing Facility	$697	-1%	-4%	0%	-4%
Emergency Medicine	$3,021	-6%	-2%	1%	-7%
Endocrinology	$488	11%	5%	1%	16%
Family Practice	$6,019	8%	4%	1%	12%
Gastroenterology	$1,713	-2%	-1%	-1%	-4%
General Practice	$405	5%	2%	0%	8%
General Surgery	$2,031	-3%	-1%	0%	-4%
Geriatrics	$187	2%	1%	0%	3%
Hand Surgery	$226	-1%	0%	0%	-1%
Hematology/Oncology	$1,673	8%	4%	1%	12%
Independent Laboratory	$592	-3%	-1%	0%	-4%
Infectious Disease	$640	-3%	-1%	0%	-3%
Internal Medicine	$10,507	2%	2%	0%	4%
Interventional Pain Mgmt	$885	4%	3%	1%	8%
Interventional Radiology	$432	-3%	-3%	0%	-6%
Multispecialty Clinic/Other Phys	$148	-2%	0%	0%	-2%
Nephrology	$2,164	-2%	0%	0%	-2%
Neurology	$1,503	2%	5%	0%	8%
Neurosurgery	$802	-3%	-1%	-2%	-6%
Nuclear Medicine	$50	-4%	0%	0%	-5%
Nurse Anes / Anes Asst	$1,291	-7%	-2%	0%	-9%
Nurse Practitioner	$4,503	5%	3%	0%	8%
Obstetrics/Gynecology	$620	4%	3%	0%	7%
Ophthalmology	$5,398	-4%	-5%	0%	-10%
Optometry	$1,325	-2%	-3%	0%	-5%
Oral/Maxillofacial Surgery	$71	-1%	-1%	-1%	-4%
Orthopedic Surgery	$3,734	-1%	0%	0%	-2%
Other	$34	-3%	-2%	0%	-5%
Otolaryngology	$1,225	3%	2%	0%	5%
Pathology	$1,203	-5%	-3%	-1%	-8%
Pediatrics	$62	3%	2%	0%	6%
Physical Medicine	$1,110	-2%	0%	0%	-2%
Physical/Occupational Therapy	$4,248	-4%	-3%	0%	-8%
Physician Assistant	$2,637	4%	2%	0%	7%
Plastic Surgery	$369	-3%	-1%	-1%	-5%
Podiatry	$1,998	0%	1%	0%	1%

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Open Payments: Changes Final for 2020 "The Sunshine Act"

- Section 6111 of the SUPPORT Act expanded the definition of covered recipients from physicians and teaching hospitals to include PAs, NPs, CNSs, CRNAs, and CNMs; it likewise expanded to these individuals the same exception for manufacturer-employment.
- New categories for reporting categories
  - Debt forgiveness
  - Long-term supply or device loan
  - Acquisition
- Must report National Drug Codes ("NDCs") for all drugs, not just those used in research.

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Section 603: Payment for 2020????

- These hospital-owned provider-based entities from 11/2/2015 will continue to be paid at 40% of the HOPPS rate.
- A higher reduction was Final last year, but CMS finds that this rate encourages parity.

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Are You Missing Reimbursement?

Code Number	Description	Non-Facility $	Facility $	Type
G0506	Assessment for Chronic Care Management	$ 63.52	$ 46.56	CCM
G2010	Remot image submit by pt	$ 12.27	$ 9.38	Telehealth
G2012	Brief check in by md/qhp	$ 14.80	$ 13.35	Telehealth
G2058	Additional 20 minutes of CCM	$ 37.89	$ 28.51	CCM
G2061	Qual nonmd est pt 5-10m	$ 12.27	$ 12.27	Telehealth
G2062	Qual nonmd est pt 11-20m	$ 21.65	$ 21.65	Telehealth
G2063	Qual nonmd est pt 21>min	$ 33.92	$ 33.56	Telehealth
G2064	MD mang high risk dx 30	$ 92.03	$ 78.68	PCM
G2065	Clin NPP mang h risk dx 30	$ 39.70	$ 39.70	PCM
99487	Complex Chronic Care Management	$ 92.39	$ 53.41	CCM
99489	Complex Chronic Care Management, Add-on 30 minutes	$ 44.75	$ 26.35	CCM
99490	Chronic Care Management, 20 minutes per month	$ 42.22	$ 32.84	CCM
99491	Chrnc care mgmt svc 30 min by MD	$ 84.09	$ 84.09	CCM
99495	Transitional Care Management, 14 days	$ 187.67	$ 125.59	TCM
99496	Transitional Care Management, 7 days	$ 247.94	$ 165.65	TCM
99497	Advanced Care Planning, first 30 minutes	$ 86.98	$ 80.48	ACP
99498	Advanced Care Planning, Add-on 30 minutes	$ 76.15	$ 75.79	ACP
99358	Prolonged Services W/Out Face-to-Face Contact, first hour	$ 113.76	$ 113.76	PS
99359	Prolonged Services W/Out Face-to-Face Contact, Add-on 30 minutes	$ 54.72	$ 54.72	PS
99415	Staff Prolonged Services Following E/M, first hour	$ 10.08	$ 10.08	PS
99416	Staff Prolonged Services Following E/M, Add-on 30 minutes	$ 4.68	$ 4.68	PS
99446	Ntrprof ph1/ntrnet/ehr 5-10	$ 18.41	$ 18.41	Telehealth
99447	Ntrprof ph1/ntrnet/ehr 11-20	$ 37.17	$ 37.17	Telehealth
99448	Ntrprof ph1/ntrnet/ehr 21-30	$ 55.58	$ 55.58	Telehealth
99449	Ntrprof ph1/ntrnet/ehr 31/>	$ 73.98	$ 73.98	Telehealth
99451	Ntrprof ph1/ntrnet/ehr 5/>	$ 37.53	$ 37.53	Telehealth
99452	Ntrprof ph1/ntrnet/ehr rfrl	$ 37.53	$ 37.53	Telehealth
99483	Assessment of and care planning for a patient with cognitive impairment	$ 241.92	$ 178.92	BHM
99484	Care management services for behavioral health conditions, at least 20 minutes of clinical staff time	$ 48.60	$ 32.76	BHM
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month	$ 161.28	$ 90.36	BHM
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month	$ 128.88	$ 81.72	BHM
99494	Initial or subsequent psychiatric collaborative care management, each additional 30 minutes in a calendar month of behavioral health care manager activities	$ 66.60	$ 43.56	BHM

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Guess What! You Probably Are…11 Months of 2019

For 2200 Physicians in 725 locations….

Total E&M Patients: on 99201 - 99215: 509,869	99490 Billed Charge Total: 1523	99495 Billed Charge Total: 204	99497 Billed Charge Total: 732

Total Distinct OCM Patient count: 40,101			Total E&M Patients: on 99201 - 99215: 509,869		99490 Billed Charge Total: 1523	99495 Billed Charge Total: 204	99497 Billed Charge Total: 732
Eligible	469768				2818608	28792	469768
Minus Billed					-1523	-204	-732
Net Eligible					2817085	28588	469036
Price					$42.84	$167.04	$86.04
Percntage					75%	75%	50%
Money Wasted					$90,512,941.05	$3,581,504.64	$20,177,928.72
Grand Total						**$114,272,374.41**	
% of Community total						40%	
All Community						**$285,680,936.03**	

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THE QPP & MIPS Final RULE for 2020

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Some Changes Final for MIPs 2020

- For MIPS, CMS proposes several changes, including:
  - For the Quality performance category:
    - Increasing the data completeness threshold to 70%,• Continuing to remove low-bar, standard of care, process measures as we further implement our Meaningful Measures framework,
    - Addressing benchmarking for certain measures to avoid potentially incentivizing inappropriate treatment,
    - Focusing on high-priority outcome measures, and
    - Adding new specialty sets (Speech Language Pathology, Audiology, Clinical Social Work, Chiropractic Medicine, Pulmonology, Nutrition/Dietician, and Endocrinology).
  - For the Cost performance category:
    - Adding 10 new episode-based measures to continue expanding access to this performance category, and
    - Revising the existing Medicare Spending Per Beneficiary Clinician and Total Per Capita Cost measures.
  - For the Improvement Activities performance category:
    - Reducing barriers to patient-center medical home designation by removing specific examples of entity names of accreditation organizations or comparable specialty practice programs;
    - Increasing the participation threshold for group reporting from a single clinician to 50% of the clinicians in the practice needing to perform the same improvement activity; we are finalizing our proposal with modification, such that instead of requiring that a group must perform the same activity for the same continuous 90 days in the performance period as proposed, we are requiring that a group must perform the same activity during any continuous 90-day period within the same performance year;
    - Updating the Improvement Activity Inventory and establishing factors for consideration for removal; and
    - Concluding the CMS Study on Factors Associated with Reporting Quality Measures.

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Some Changes Final for MIPs 2020

- For MIPS, CMS proposes several changes, including:
  - For Promoting Interoperability performance category:
    - Including the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure (available for bonus points)
    - Removing the Verify Opioid Treatment Agreement measure
    - Reducing the threshold for a group to be considered hospital-based (Instead of 100% of clinicians, more than 75% of the clinicians in a group must be a hospital-based individual MIPS eligible clinician in order for the group to be excluded from reporting the measures under the Promoting Interoperability performance category and to have this category reweighted to zero.)

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New Term: MIPS Value Pathways ("MVP")

- In addition, CMS Final implementing a new conceptual framework for MIPS, called MIPS Value Pathways (MVPs), which would start in the 2021 performance period. CMS said the new framework "would move MIPS from its current state, which requires clinicians to report on many measures across the multiple performance categories, such as quality, cost, promoting interoperability, and improvement activities, to a system in which clinicians will report much less."
- According to CMS, clinicians under MVPs would report on a reduced set of measures that are:
  - More closely aligned with alternative payment models (APMs);
  - Outcome-based;
  - Connects all 4 categories in MIPS; and
  - Specific to a clinician's specialty or a given condition.
- CMS said MVPs also would allow the agency "to provide more data and feedback to clinicians," which could help clinicians "quickly identify strengths in performance as well as opportunities for continuous improvement in order to deliver the best outcomes possible for patients."

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MIPS Value Pathways

Current Structure of MIPS (In 2020)

- Many Choices
- Not Meaningfully Aligned
- Higher Reporting Burden

Quality — 6+ Measures
Promoting Interoperability — 6+ Measures
Improvement Activities — 2-4 Activities
Cost — 1 or More Measures

New MIPS Value Pathways Framework (In Next 1-2 Years)

- Cohesive
- Lower Reporting Burden
- Focused Participation around Pathways that are Meaningful to Clinician's Practice/Specialty or Public Health Priority

Building Pathways Framework

MIPS Value Pathways
Clinicians report on fewer measures and activities base on specialty and/or outcome within a MIPS Value Pathway

Moving to Value

Quality
Improvement Activities
Cost

Foundation
Promoting Interoperability
Population Health Measures

Future State of MIPS (In Next 3-5 Years)

- Simplified
- Increased Voice of the Patient
- Increased CMS Provided Data
- Facilitates Movement to Alternative Payment Models (APMs)

Fully Implemented Pathways

Continue to increase CMS provided data and feedback to reduce reporting burden on clinicians

Value

Cost
Quality and IA aligned

Foundation
Promoting Interoperability
Population Health Measures
Enhanced Performance Feedback
Patient-Reported Outcomes

Population Health Measures: *a set of administrative claims-based quality measures that focus on public health priorities and/or cross-cutting population health issues; CMS provides the data through administrative claims measures, for example, the All-Cause Hospital Readmission measure.*

Clinician/Group Reported Data
CMS Provided Data

Goal is for clinicians to report less burdensome data as MIPS evolves and for CMS to provide more data through administrative claims and enhanced performance feedback that is meaningful to clinicians and patients.

We Need Your Feedback on:

Pathways:
What should be the structure and focus of the Pathways?
What criteria should we use to select measures and activities?

Participation:
What policies are needed for small practices and multi-specialty practices?
Should there be a choice of measures and activities within Pathways?

Public Reporting:
How should information be reported to patients?
Should we move toward reporting at the individual clinician level?

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Medicare Learning Network

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TABLE 44: Episode-Based Measures Proposed for the 2020 Performance Period and Future Performance Periods

Measure Topic	Episode Measure Type
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural
Elective Primary Hip Arthroplasty	Procedural
Femoral or Inguinal Hernia Repair	Procedural
Hemodialysis Access Creation	Procedural
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition
Lower Gastrointestinal Hemorrhage*	Acute inpatient medical condition
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural
Lumpectomy Partial Mastectomy, Simple Mastectomy	Procedural
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural
Renal or Ureteral Stone Surgical Treatment	Procedural

*This measure was proposed only for groups. Please reference section III.K.3.c.(2)(b)(vi)(B) of this final rule.

- The detailed specifications for these 10 episode-based measures are available on the MACRA Feedback page (https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/MACRA-MIPS-and-APMs/MACRA-Feedback.html

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QPP: MIPS Year 4 (2020) Final

Policy Area	CY 2019 Policy	CY 2020 Policy
Performance Category Weights	• Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%	**No change:** • Quality: 45% • Cost: 15% • Promoting Interoperability: 25% • Improvement Activities: 15%
Quality Performance Category	**Data Completeness Requirements:** • Medicare Part B Claims measures: 60% of Medicare Part B patients for the performance period • QCDR measures, MIPS CQMs, and eCQMs: 60% of clinician's or group's patients across all payers for the performance period	**Data Completeness Requirements:**[1] • Medicare Part B Claims measures: **70%** sample of Medicare Part B patients for the performance period • QCDR measures, MIPS CQMs, and eCQMs: **70%** sample of clinician's or group's patients across all payers for the performance period Note: Using data selection criteria to misrepresent a clinician or group's performance for a performance period, commonly referred to as "cherry-picking", results in data that is not true, accurate, or complete.

MIPS Proposals for 2020

Payment Thresholds:

Performance Period	Performance Threshold	Exceptional Performance Bonus	Payment Adjustment*
Year 1 (2017)	3 points	70 points	Up to +4%
Year 2 (2018)	15 points	70 points	Up to +5%
Year 3 (2019)	30 points	75 points	Up to +7%
Year 4 (2020) Proposed	**45 points**	**80 points**	**Up to +9%**
Year 5 (2021) Proposed	**60 points**	**85 points**	**Up to +9%**

*Payment adjustment (and exceptional performer bonus) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance. To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a "scaling factor." The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.

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TABLE 60: Illustration of Point System and Associated Adjustments Comparison between the 2020 MIPS Payment Year, the 2021 MIPS Payment Year, and the Policies for the 2022 MIPS Payment Year and the 2023 MIPS Payment Year

2020 MIPS payment year		2021 MIPS payment year		2022 MIPS payment year		2023 MIPS payment year	
Final Score Points	**MIPS Adjustment**	**Final Score Points**	**MIPS Adjustment**	**Final Score Points**	**MIPS Adjustment**	**Final Score Points**	**MIPS Adjustment**
0.0-3.75	Negative 5%	0.0-7.5	Negative 7%	0.0-11.25	Negative 9%	0.0-15.0	Negative 9%
3.76-14.99	Negative MIPS payment adjustment greater than negative 5% and less than 0% on a linear sliding scale	7.51-29.99	Negative MIPS payment adjustment greater than negative 7% and less than 0% on a linear sliding scale	11.26-44.99	Negative MIPS payment adjustment greater than negative 9% and less than 0% on a linear sliding scale	15.01-59.99	Negative MIPS payment adjustment greater than negative 9% and less than 0% on a linear sliding scale
15.0	0% adjustment	30.0	0% adjustment	45.0	0% adjustment	60.0	0% adjustment
15.01-69.99	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 5% for scores from 15.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality	30.01-74.99	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 7% for scores from 30.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality	45.01-84.99.	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 9% for scores from 45.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality	60.01-84.99	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 9% for scores from 60.00 to 100.00. This sliding scale is multiplied by a scaling factor greater than zero but not exceeding 3.0 to preserve budget neutrality
70.0-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 5% for final scores from 15.00 to 100.00. This sliding scale is multiplied by a	75.0-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 7% for final scores from 30.00 to 100.00. This sliding scale is multiplied by a	85.0-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges from 0 to 9% for final	85.0-100	Positive MIPS payment adjustment greater than 0% on a linear sliding scale. The linear sliding scale ranges

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Quality Payment Program: Advanced Alternative Payment Models (APMs) Year 4 (2020) Final

- For Advanced APMs, CMS is:
  - maintaining the existing 8 percent revenue-based nominal risk standard through performance year 2024;
  - applying partial qualifying APM participant (QP) status only to the tax identification number/national provider identifier combination(s) through which an individual eligible clinician attains partial QP status, beginning with the 2020 QP performance period; and
  - requesting comment on APM scoring beyond 2020 which is no a lump sum of 5%.

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For Further Information

See the Physician Fee Schedule website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html

See the MIPs website at:

https://qpp.cms.gov

Final Rule Hospital Outpatient Payment 2020

2020 Final HOPPS Drug Payments

All non-pass-through drugs whose cost is $130 or less per encounter, according to CMS, will be bundled into the APC. This a $5 increase from last year. The usual…

Pay non-pass-through drugs and biosimilars acquired under the 340B program at ASP minus 22.5%. But, if lawsuit prevails, they may go to ASP plus 3%.

Display Copy Final Hospital Outpatient Rule, page 274;
Final Rule, Display Copy, page 23

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Facility Fees Proposal: Control of "Unnecessary Services"

- Hospital facility fees have long been controversial.
- So, starting in 2019, CMS decided to enforce a Physician Fee Schedule (PFS)-equivalent payment rate for the clinic visit service when provided at an off-campus provider-based department (PBD) that is paid under the OPPS. The clinic visit is the most common service billed under the OPPS. Currently, Medicare and beneficiaries often pay more for the same type of clinic visit in the hospital outpatient setting than in the physician office setting.
- CMS indicated its intent to reduce over a two-year period the payment rate for outpatient office visits (HCPCS G0463) at excepted, off-campus PBDs to 40 percent of the OPPS payment rate. In last year's final rule, CMS reduced payments for office visits to excepted, off-campus PBDs to 70 percent of the OPPS rate for the first year of this policy. As promised, CMS now proposes reducing payment to 40 percent in CY 2020
- A Judge ruled against this provision on 9/17/2019; may be rescinded or put on hold.

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Section 603: Payment for 2018-2020 (In the PFS Rule from 2019)

These entities will still be paid at 40% of the HOPPS rate

- This does not include drugs or labs

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Price Transparency 2020 Proposal—

- ~~The OPPS Final rule includes policies that build on hospitals' existing requirements on posting charges. Price transparency proposals include:~~
  - ~~definitions of "hospital," "standard charges," and "items and services";~~
  - ~~requirements for making public a machine-readable file online that includes all standard charges for all hospital items and services;~~
  - ~~requirements for making public payer-specific negotiated charges for a limited set of services, displayed and packaged in a consumer-friendly manner; and~~
  - ~~actions to monitor compliance and address hospital noncompliance.~~
- Will be addressed in a separate Final Rule

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Payment Update for APCs

- In accordance with Medicare law, CMS is proposing to update OPPS payment rates by 2.6 percent. This update is based on the projected hospital market basket increase of 3.0 percent minus a 0.5 percentage point adjustment for multi-factor productivity (MFP).
- Per https://www.cms.gov/newsroom/fact-sheets/cy-2020-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center

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Part D: Benefit Design 2020

Medicare Part D Benefit Parameters for Defined Standard Benefit 2015 through 2020 Comparison					
Part D Standard Benefit Design Parameters:	**2020**	**2019**	**2018**	**2017**	**2016**
Deductible - After the Deductible is met, Beneficiary pays 25% of covered costs up to total prescription costs meeting the Initial Coverage Limit.	$435	$415	$405	$400	$360
Initial Coverage Limit - Coverage Gap (Donut Hole) begins at this point. (The Beneficiary pays 100% of their prescription costs up to the Out-of-Pocket Threshold)	$4,020	$3,820	$3,750	$3,700	$3,310
Out-of-Pocket Threshold - This is the Total Out-of-Pocket Costs including the Donut Hole.	$6,350	$5,100	$5,000	$4,950	$4,850
Total Covered Part D Drug Out-of-Pocket Spending including the Coverage Gap - Catastrophic Coverage starts after this point. See note (1) below.	$9,038.75 (1)	$7,653.75 (1)	$7,508.75 (1)	$7,425.00 (1)	$7,062.50 (1)
Total Estimated Covered Part D Drug Out-of-Pocket Spending **including the Coverage Gap Discount (NON-LIS)** See note (2).	$9,719.38 plus a 75% brand discount	$8,139.54 plus a 75% brand discount	$8,417.60 plus a 65% brand discount	$8,071.16 plus a 60% brand discount	$7,515.22 plus a 55% brand discount
Average NON-LIS percentage brand and generic drug purchases made during the coverage gap used to estimate the Total Covered Part D OOP threshold for NON-LIS beneficiaries (see above).	Brand: 90.18% Generic: 9.82%	Brand: 89.31% Generic: 10.69%	Brand: 89.18% Generic: 10.82%	Brand: 87.9% Generic: 12.1%	Brand: 84.6% Generic: 15.4%
Catastrophic Coverage Benefit:					
Generic/Preferred Multi-Source Drug (3)	$3.60 (3)	$3.40 (3)	$3.35 (3)	$3.30 (3)	$2.95 (3)
Other Drugs (3)	$8.95 (3)	$8.50 (3)	$8.35 (3)	$8.25 (3)	$7.40 (3)

ICD-10-CM Changes for Hem-Onc

OCTOBER 1, 2019

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Hematology

- Add: D75.A Glucose-6-phosphate dehydrogenase (G6PD) deficiency without anemia
- Delete: D81.3 Adenosine deaminase [ADA] deficiency
- Add: D81.30 Adenosine deaminase deficiency, unspecified
- Add: D81.31 Severe combined immunodeficiency due to adenosine deaminase deficiency
- Add: D81.32 Adenosine deaminase 2 deficiency
- Add: D81.39 Other adenosine deaminase deficiency

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Drug Reactions

- Add: T50.911A Poisoning by multiple unspecified drugs, medicaments and biological substances, accidental (unintentional), initial encounter
- Add: T50.911D Poisoning by multiple unspecified drugs, medicaments and biological substances, accidental (unintentional), subsequent encounter
- Add: T50.911S Poisoning by multiple unspecified drugs, medicaments and biological substances, accidental (unintentional), sequela
- Add: T50.912A Poisoning by multiple unspecified drugs, medicaments and biological substances, intentional self-harm, initial encounter
- Add: T50.912D Poisoning by multiple unspecified drugs, medicaments and biological substances, intentional self-harm, subsequent encounter
- Add: T50.912S Poisoning by multiple unspecified drugs, medicaments and biological substances, intentional self-harm, sequela
- Add: T50913A Poisoning by multiple unspecified drugs, medicaments and biological substances, assault, initial encounter
- Add: T50.913D Poisoning by multiple unspecified drugs, medicaments and biological substances, assault, subsequent encounter
- Add: T50.913S Poisoning by multiple unspecified drugs, medicaments and biological substances, assault, sequela
- Add: T50.914A Poisoning by multiple unspecified drugs, medicaments and biological substances, undetermined, initial encounter
- Add: T50.914D Poisoning by multiple unspecified drugs, medicaments and biological substances, undetermined, subsequent encounter
- Add: T50.914S Poisoning by multiple unspecified drugs, medicaments and biological substances, undetermined, sequela
- Add: T50.915A Adverse effect of multiple unspecified drugs, medicaments and biological substances, initial encounter
- Add: T50.915D Adverse effect of multiple unspecified drugs, medicaments and biological substances, subsequent encounter
- Add: T50.915S Adverse effect of multiple unspecified drugs, medicaments and biological substances, sequela
- Add: T50.916A Underdosing of multiple unspecified drugs, medicaments and biological substances, initial encounter
- Add: T50.916D Underdosing of multiple unspecified drugs, medicaments and biological substances, subsequent encounter
- Add: T50916S Underdosing of multiple unspecified drugs, medicaments and biological substances, sequela

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Personal history

- Add: Z86.002 Personal history of in-situ neoplasm of other and unspecified genital organs
- Add: Z86.003 Personal history of in-situ neoplasm of oral cavity, esophagus and stomach
- Add: Z86.004 Personal history of in-situ neoplasm of other and unspecified digestive organs
- Add: Z86.005 Personal history of in-situ neoplasm of middle ear and respiratory system
- Add: Z86.006 Personal history of melanoma in-situ
- Add: Z86.007 Personal history of in-situ neoplasm of skin

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CPT/HCPCS Code Changes

Dates of Service 7/1/2019 and Thereafter

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HCPCS Additions 2020: Drugs

J0121	ADD	Inj., omadacycline, 1 mg Injection, omadacycline, 1 mg	NUZYRA
J0122	ADD	Inj., eravacycline, 1 mg Injection, eravacycline, 1 mg	Xerava
J0291	ADD	Inj., plazomicin, 5 mg Injection, plazomicin, 5 mg	Zemdri
J0593	ADD	Inj., lanadelumab-flyo, 1 mg Injection, lanadelumab-flyo, 1 mg (code may be used for medicare when	Takhzyro
J0642	ADD	Injection, khapzory, 0.5 mg Injection, levoleucovorin (khapzory), 0.5 mg	Levoleucovoin/Khapzory
J1303	ADD	Inj., ravulizumab-cwvz 10 mg Injection, ravulizumab-cwvz, 10 mg	Ultomiris
J1444	ADD	Fe pyro cit pow 0.1 mg iron Injection, ferric pyrophosphate citrate powder, 0.1 mg of iron	Triferic
J1943	ADD	Inj., aristada initio, 1 mg Injection, aripiprazole lauroxil, (aristada initio), 1 mg	ARISTADA Initio
J1944	ADD	Aripirazole lauroxil 1 mg Injection, aripiprazole lauroxil, (aristada), 1 mg	ARISTADA
J2798	ADD	Inj., perseris, 0.5 mg Injection, risperidone, (perseris), 0.5 mg	Perseris
J3031	ADD	Inj., fremanezumab-vfrm 1 mg Injection, fremanezumab-vfrm, 1 mg (code may be used for medicare when	AJOVY
J3111	ADD	Inj. romosozumab-aqqg 1 mg Injection, romosozumab-aqqg, 1 mg	EVENITY
J7208	ADD	Inj. jivi 1 iu Injection, factor viii, (antihemophilic factor, recombinant), pegylate	Jivi
J9030	ADD	Bcg live intravesical 1mg Bcg live intravesical instillation, 1 mg	BCG
J9036	ADD	Inj. belrapzo/bendamustine Injection, bendamustine hydrochloride, (belrapzo/bendamustine), 1 mg	Belrapzo
J9118	ADD	Inj. calaspargase pegol-mknl Injection, calaspargase pegol-mknl, 10 units	Asparias
J9119	ADD	Inj., cemiplimab-rwlc, 1 mg Injection, cemiplimab-rwlc, 1 mg	Libtayo
J9199	ADD	Injection, infugem, 200 mg Injection, gemcitabine hydrochloride (infugem), 200 mg	Infugem
J9204	ADD	Inj mogamulizumab-kpkc, 1 mg Injection, mogamulizumab-kpkc, 1 mg	Poteligeo
J9210	ADD	Inj., emapalumab-lzsg, 1 mg Injection, emapalumab-lzsg, 1 mg	Gamifant
J9269	ADD	Inj. tagraxofusp-erzs 10 mcg Injection, tagraxofusp-erzs, 10 micrograms	Elzonris
J9309	ADD	Inj, polatuzumab vedotin 1mg Injection, polatuzumab vedotin-piiq, 1 mg	Polivy
J9313	ADD	Inj., lumoxiti, 0.01 mg Injection, moxetumomab pasudotox-tdfk, 0.01 mg	Lumoxiti
J9356	ADD	Inj. herceptin hylecta, 10mg Injection, trastuzumab, 10 mg and hyaluronidase-oysk	Herceptin Hylecta

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HCPCS Additions 2020: Biosimilars

Q5112	ADD	Inj ontruzant 10 mg	Injection, trastuzumab-dttb, biosimilar, (ontruzant), 10 mg	Ontruzant
Q5113	ADD	Inj herzuma 10 mg	Injection, trastuzumab-pkrb, biosimilar, (herzuma), 10 mg	Herzuma
Q5114	ADD	Inj ogivri 10 mg	Injection, trastuzumab-dkst, biosimilar, (ogivri), 10 mg	Ogivri
Q5115	ADD	Inj truxima 10 mg	Injection, rituximab-abbs, biosimilar, (truxima), 10 mg	Truxima
Q5116	ADD	Inj., trazimera, 10 mg	Injection, trastuzumab-qyyp, biosimilar, (trazimera), 10 mg	Trazimera
Q5117	ADD	Inj., kanjinti, 10 mg	Injection, trastuzumab-anns, biosimilar, (kanjinti), 10 mg	Kanjinti
Q5118	ADD	Inj., zirabev, 10 mg	Injection, bevacizumab-bvzr, biosimilar, (zirabev), 10 mg	Zirabev

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Other Proposals

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Final Radiation Oncology CMMI Model

- The Final RO Model would take significant steps towards making prospective, episode-based payments in a site-neutral manner for 17 different cancer types. The Model would further the Innovation Center's efforts to test site-neutral models and to test patient-centered, physician-focused models that provide an opportunity for physicians to participate in an Advanced Alternative Payment Model (APM) under the Quality Payment Program (QPP)
- Final Rule at https://www.hhs.gov/sites/default/files/CMS-5527-P.pdf to begin in 2020 and continue until 12/31/2024.
- The RO Model would require participation from RT providers and suppliers that furnish RT services within randomly selected Core Based Statistical Areas. It will not be everyone like the OCM. But, participation in those areas will be mandatory.
- Model episode payments would be split into a professional component (PC) payment. The discount factor for the PC would be 4%, and the discount factor for the TC would be 5%. The payment amount would also be prospectively adjusted for withholds for incomplete episodes (2% for PC and TC), quality (2% for PC), and beneficiary experience (1% for TC starting in 2022).

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Radiation Oncology CMMI Model

- On Wednesday, July 10, 2019, the Centers for Medicare and Medicaid Innovation Center issued a proposed rule establishing a Radiation Oncology Alternative Payment Model (RO Model), requiring participation from approximately 40% of radiation oncology practices. AThe "RO Model" is proposed to establish a 90-day episode of care for 17 disease sites that are prospectively paid using a site neutral payment methodology. As proposed, the RO Model meets Advanced Alternative Payment Model (APM) requirements by satisfying the Medicare Access and CHIP Reauthorization Act (MACRA) Advanced APM nominal risk requirement, inclusion of MIPS comparable measures and Certified Electronic Health Records Technology (CHERT) utilization requirements.
- According to the proposed rule, the RO Model is designed to test whether prospective episode-based payments to physician group practices (PGPs), hospital outpatient departments (HOPDs), and freestanding radiation therapy centers for episodes of care would reduce Medicare expenditures while preserving or enhancing the quality of care for Medicare beneficiaries. The Agency proposes launching the model either January 1, 2020 or April 1, 2020, and estimates savings of $250-260 million (or 3%) over the Model's five-year implementation period. CMS asserts that the RO Model's episode payment is designed to give radiation oncologists greater predictability in payment and greater opportunity to clinically manage episodes of care, rather than being driven by Fee-For-Service payment incentives.
- Advanced RO modalities like IMRT and SBRT will be included.
- For more info, go to https://www.cms.gov/newsroom/fact-sheets/Final-radiation-oncology-ro-model. Or, https://www.astro.org/News-and-Publications/What-is-Happening-in-Washington/2019/CMMI-Radiation-Oncology-Alternative-Payment-Model

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One Final Thought About Future E/M Services

GET YOUR PROVIDERS TO LEARN TO DOCUMENT TIME!!!!!!

To Dos for 2020

- Time for time—physicians and NPPs need to learn to regard visit time as more important than ever. This is the opposite of what they have been told to do.
- Check and ensure that you are billing for everything you can get done in your practice or clinic.
- Know all about the deadlines for filing claims in your area.
- Watch for ‘temporary’ plans which may have caps and limits.
- Make sure your ACA and Medicare patients have paid their premiums.
- Medicare is increasingly picky about ICD-10-CM—no unspecified codes and no ‘other’ in anemia, NHL and RA.
- Check for Step Therapy MA plans. It can be appealed, btw.
- Participate in the Struggle…forever...

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