ANCO's 2020 Professional Education Meeting

October 29th, 2020

ANCO

Educating and Empowering the
Northern California Cancer Community

The opinions expressed in this publication are those of the participating faculty and not necessarily those of the *Association of Northern California Oncologists* (ANCO), its members, or any supporters of this meeting.

ANCO's 2020 Professional Education Meeting

Thursday, October 29th, 2020; 8AM-11:30AM

Agenda & Schedule

8:00AM **Opening Remarks & Introductions**
Courtney Flookes, *ANCO Executive Director*

8:05AM **Preparing for 2021 E&M Coding Changes**
Elaine Towle, CPME, *Elaine Towle Consulting, LLC*

9:05AM Coffee break and virtual exhibits

9:30AM **Hot Topics in Reimbursement 2020-2021**
Bobbi Buell, MBA, *onPoint Oncology*

10:30AM **Medicare for Oncologists During the COVID Crisis and Beyond**
Arthur Lurvey, MD, ***FACP, FACE*** *Noridian Healthcare Solutions, LLC, Fargo*

11:30AM ADJOURN

Acknowledgement of Commercial Support

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Preparing for 2021 E&M Coding Changes

Elaine Towle, CPME
Elaine Towle Consulting, LLC

Presentation

Evaluation & Management Coding Changes 2021

ANCO ANNUAL PROFESSIONAL EDUCATION MEETING 2020 ~ VIRTUAL

OCTOBER 29, 2020

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DISCLAIMER

While all information in this document is believed to be correct at the time of writing, this document is for educational purposes only and does not purport to provide legal or business advice.

All coding should be aimed at individual patients and payer needs and requirements.

The speaker and the corporation they represent accepts no liability for coding decisions made by individuals.

All models, methodologies and guidelines are undergoing continuous change. This presentation may contain information that may not be valid.

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Learning Objectives

Learn what will change and what will not change in 2021; understand that not ALL E/M codes have changed.

Understand that clinicians can choose one of two criteria to assign codes in the 99202 – 99215 code range.

Describe how Time and Medical Decision Making - the two main E/M criteria - have been modified for 2021.

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Goals of the CPT E/M 2021 Presentation

Should be a spark for you and members of your clinical staff to carefully read the CPT 2021. Why?

- Criteria for office and HOPD visits have been much more well defined in terms of clearer explanations. These should be read.
- There is a need to compare and contrast criteria for 99202-99215 with other E/M services – these changes DO NOT apply to all E/M services.
- Understand both criteria (Time and MDM) for these visits thoroughly and make the choice based on what fits each clinician's documentation strengths.

Should also be a catalyst to meet with your EMR vendor to see what they are doing to help.

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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 and in CPT 2021.

- Much of what we knew over the last 2 years has been upheld, but there are changes and modifications from CMS.

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What is New in 2021?

Summary of CPT Guideline Differences

***CPT 2021 Professional Edition*, American Medical Association**

Component(s) for Code Selection	Office or Other Outpatient Services *99202 - 99215*	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home)
History and Examination	As medically appropriate Not used in code selection	Use key components (history, examination, MDM)
Medical Decision Making (MDM)	May use MDM or total time on the date of the encounter	Use key components (history, examination, MDM)
Time	May use MDM or total time on the date of the encounter	May use face-to-face time or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates the service *Time is NOT a descriptive component for the emergency department levels of E/M services.*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality

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Other Things of Note in E/M 2021

- No more 99201
- 99211 is for clinical staff only
- Changes are for 99202-99215 ONLY; all other E/M stays the same
- 1995 and 1997 documentation guidelines are over for Office and Outpatient E/M, but not for other services
- New definition of Medical Decision Making
- Visit times are in ranges and not in exact numbers
- Prolonged services are used for Level 5 visits only for 99202-99215

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Criteria: Medical Decision Making

ONE OF TWO E/M CRITERIA FOR 99202-99215

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E/M Definition (2021): Medical Decision Making ("MDM") *American Medical Association*

MDM includes establishing the diagnoses; assessing the status of a condition; and/or selecting a management option.

MDM is defined by these three elements:

- The number and complexity of problems that are addressed during the encounter;
- The amount and/or complexity of data to be reviewed/analyzed. These data may include medical records, tests, and/or other data that must be analyzed or interpreted by the treating professional or in consultation with other providers.
- The risk of complications and/or comorbidities or morbidity associated with the patient's problem, the diagnostic procedures or prospective treatment options.

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Medical Decision-Making

Code	Level of MDM 2 or 3 elements	Number and Complexity of Problems Addressed	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
99202 99212	Straight forward	**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)	**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 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**) (in the field right above,)	**High risk** of morbidity from additional diagnostic testing or treatment Examples only: • Drug therapy requiring intensive monitoring for toxicity • Decision regarding elective major procedure 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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Levels of Medical Decision Making Criteria
Number and Complexity of Problems

Code Levels	Level of MDM	Number & Complexity of Problems
99202 99212	Straight Forward	• 1 Self Limited Problem
99203 99213	Low	• 2 or more Self-limited or Minor problems • 1 Stable Chronic Illness • 1 Uncomplicated Illness or Injury
99204 99214	Moderate	• One or more chronic illnesses with mild exacerbation, progression, or side effects of treatment • Two or more stable chronic illnesses • Undiagnosed new problem with uncertain prognosis (for example, lump in breast) • Acute illness with systemic symptoms (for example, pyelonephritis, pneumonitis, colitis) • Acute complicated injury (for example, head injury with brief loss of consciousness)
99205 99215	High	• 1 or more chronic illnesses with severe exacerbation, side effects of treatment, or progression • 1 acute or chronic illness which pose a risk to life and/or bodily function

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MDM: Number and Complexity of Problems

Comorbidities and/or chronic problems are only considered in medical decision-making if they are addressed during the encounter. If these are being addressed by another provider without an independent assessment, they are not counted.

Comorbidities are not considered unless the status changes or unless they directly impact data reviewed or treatment decisions.

Multiple problems of lower severity may in the aggregate create higher risk in decision-making.

Threats to life or limb must be part of the encounter in which you are billing, not long term.

The final diagnosis does not necessarily drive the MDM; it is more the process to reach the diagnosis.

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Levels of Medical Decision Making Amount and Complexity of Data

Data is divided into "category" which is a change from the old definition of MDM

- Category 1: Tests and Documents
  - Any combination of 2 from the following for lower levels:
    - Review of prior external notes from a unique source
    - Review of the result(s) of a unique test
    - Ordering of each unique test
    - Assessment requiring independent historian (Moderate/ Extensive)
- Category 2: Independent Interpretation of Tests
  - Independent interpretation of a test performed by another physician/other NPP (not separately reported)
- Category 3: Discussion of management or test interpretation
  - Discussion with an external physician or NPP/ appropriate source (not separately reported)

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"Not Separately Reported"

This is an important concept.

Any specifically identifiable procedure or service (i.e., identified with a specific CPT code) performed on the date of E/M services may be reported separately. The actual performance and/or interpretation of diagnostic tests/studies during a patient encounter are not included in determining the levels of E/M services when reported separately.

Physician performance of diagnostic tests/studies for which specific CPT codes are available may be reported separately, in addition to the appropriate E/M code. This, of course, is subject to the usual edits. The physician's interpretation of the results of diagnostic tests/ studies (i.e., professional component) with preparation of a separate distinctly identifiable signed written report may also be reported separately, using the appropriate CPT code and, if required, with modifier 26 appended.

If a test/study is independently interpreted in order to manage the patient as part of the E/M service, but is not separately reported, it is part of medical decision making.

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Levels of Medical Decision-Making Criteria
Amount or Complexity of Data to be Reviewed

Codes	Level of MDM	Data Category
99202 99212	Straightforward	Minimal or None
99203 99213	Low	Category 1 or Category 2
99204 99214	Moderate	Must meet 1 of 3 of Category 1 (More extensive) Category 2 Category 3
99205 99215	Extensive	Must meet 2 of 3 Category 1 (More extensive) Category 2 Category 3

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Levels of Decision-Making: Risk

"The risk of complications, morbidity, and/or mortality of patient management decisions made at the visit, associated with the patient's problem(s), the diagnostic procedure(s), treatment (s). This includes the possible management options selected and those considered, but not selected, after shared medical decision making with the patient and/or family. For example, a decision about hospitalization includes consideration of alternative levels of care. Examples may include a psychiatric patient with a sufficient degree of support in the outpatient setting or the decision to not hospitalize a patient with advanced dementia with an acute condition that would generally warrant inpatient care, but for whom the goal is palliative treatment."

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Levels of Medical Decision Making Criteria
Risk of Complications and/or Morbidity or Mortality

Code Levels	Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202 99212	Straight Forward	Minimal risk of morbidity from additional diagnostic testing or treatment
99203 99213	Low	Low risk of morbidity from additional diagnostic testing or treatment
99204 99214	Moderate	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 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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MDM: Drug Monitoring with Risk of Toxicity (AMA)

"Drug therapy requiring intensive monitoring for toxicity: A drug that requires intensive monitoring is a therapeutic agent that has the potential to cause serious morbidity or death. The monitoring is performed for assessment of these adverse effects and not primarily for assessment of therapeutic efficacy. The monitoring should be that which is generally accepted practice for the agent but may be patient specific in some cases. Intensive monitoring may be long-term or short term. Long-term intensive monitoring is not less than quarterly. The monitoring may be by a lab test, a physiologic test or imaging. Monitoring by history or examination does not qualify. The monitoring affects the level of medical decision making in an encounter in which it is considered in the management of the patient. Examples may include monitoring for a cytopenia in the use of an antineoplastic agent between dose cycles or the short-term intensive monitoring of electrolytes and renal function in a patient who is undergoing diuresis. Examples of monitoring that does not qualify include monitoring glucose levels during insulin therapy as the primary reason is the therapeutic effect (even if hypoglycemia is a concern); or annual electrolytes and renal function for a patient on a diuretic as the frequency does not meet the threshold."

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Criteria: Time

ONE OF TWO E/M CRITERIA FOR 99202-99215

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Time: A New Definition (2021)

"Time" refers to the total time spent by the clinician on the date of service.

The extended visit code CANNOT be attached to any codes except Level 5

- There is a new, add-on CPT code for prolonged office/outpatient E/M visits (CPT code 99417 (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). **It is only to 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 99202-99215 on the day of the encounter.

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What does time mean???

Physician/other qualified health care professional time includes the following activities, when performed AND these must be documented in addition to time:

- preparing to see the patient (e.g., review of tests)
- obtaining and/or reviewing separately obtained history
- performing a medically appropriate examination and/or evaluation
- counseling and educating the patient/family/caregiver
- ordering medications, tests, or procedures
- referring and communicating with other health care professionals (when not separately reported)
- documenting clinical information in the electronic or other health record
- independently interpreting results (not separately reported) and communicating results to the patient/family/caregiver
- care coordination (not separately reported)

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Definition of time

This must be time spent by the billing provider, not by staff.

Time is for all activities by this person on the day of the encounter.

This includes pre- and post-work.

Cannot include time being spent on other activities which ARE NOT "not separately reported"

- Chronic Care Management billed separately
- Performing tests or procedures billed separately
- Prepping staff for drug administration billed separately

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E/M Time Ranges 2021

New patient code	Total time (2021)	Established patient code	Total time (2021)
99202	15-29 minutes	99211	N/A
99203	30-44 minutes	99212	10-19 minutes
99204	45-59 minutes	99213	20-29 minutes
99205	60-74 minutes	99214	30-39 minutes
		99215	40-54 minutes

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A Preview of Office/Outpatient Codes

Established Patient

▲99211 **Office or other outpatient visit** for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

★▲99212 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making.

When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

★▲99213 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making.

When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

★▲99214 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making.

When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

★▲99215 **Office or other outpatient visit** for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making.

When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

(For services 55 minutes or longer, see Prolonged Services 99XXX)

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99417: Prolonged Services

Beginning in 2021, there will be a new code for reporting prolonged services together with an office visit. The new code, CPT Code 99417, replaces CPT Codes 99354 and 99355. It can be used to report the total prolonged time with and without direct patient contact on the same day as an office visit. However, certain conditions apply:

- It can only be reported in conjunction with the level 5 visit codes (CPT 99205, 99215).
- The time must exceed the minimum time for primary E&M service.
- Time alone must be the basis for coding.
- Right now, CMS and the AMA disagree with how this will work.

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99417: Prolonged Services

It may not be used with any other office/ outpatient code.

It may not be used on the same date as non-face-to-face prolonged care codes 99358, 99359 or face-to-face prolonged care codes 99354, 99355.

And, the time reported must be 15 minutes, not 7.5 minutes. The entire 15 minutes must be done, in order to add on this new, prolonged services code to 99215 and 99205.

This new add-on prolonged services code may only be used with 99205 and 99215.

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AMA Definition of 96417 Thresholds

Time Duration	What is Reported
New Patient	
less than 75 minutes	Not reported separately
75-89 minutes	99205 X 1 and 99417 x 1
90-104 minutes	99205 X 1 and 99417 x 2
105 or more	99205 X 1 and 99417 x 3 or more for each additional 15 minutes.
Established Patient	
less than 55 minutes	Not reported separately
55-69 minutes	99215 X 1 and 99417 x 1
70-84 minutes	99215 X 1 and 99417 x 2
85 or more	99215 X 1 and 99417 x 3 or more for each additional 15 minutes.

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CMS: Proposes a different, more conservative start time for 99417

- 99417 (formerly 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).

TABLE 23: Proposed Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and 99XXX x 1	69-83 minutes
99215 x 1 and 99XXX x 2	84- 98 minutes
99215 x 1 and 99XXX x 3 or more for each additional 15 minutes.	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

Proposed Rule, Display Copy Page 180

Will this change in the Final Rule??

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CMS: E/M Changes for 2021

The GPC1X ("dummy code") code has been finalized but it changed a bit in definition. CMS is asking for comments. CMS described it as:

- "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 condition."
- Although they are not limiting the specialties that can use the code, they believe it will be used by primary care clinicians and other clinicians. CMS said
  - ***"we believe HCPCS add-on code GPC1X reflects the time, intensity, and PE when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. For example, in the context of primary care, HCPCS add-on code GPC1X could recognize the resources inherent in holistic, patient-centered care that integrates the treatment of illness or injury, management of acute and chronic health conditions, and coordination of specialty care in a collaborative relationship with the clinical care team."***

Question: Will your non-Medicare payers accept this?

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CMS E/M Values 2020 Versus Proposed in 2021

CPT[1]/ HCPCS	Description	Work RVUs[2]	Non-Facility PE RVUs[2]	Facility PE RVUs[2]	Mal-Practice RVUs[2]	Total Non-Facility RVUs[2]	Total Facility RVUs[2]	Global	Conversion Factor	2021 Office Price	2020 Office Price
99202	Office/outpatient visit new	0.93	1.12	0.41	0.09	2.14	1.43	XXX	$32.26	$ 69.04	$ 77.23
99203	Office/outpatient visit new	1.60	1.54	0.67	0.15	3.29	2.42	XXX	$32.26	$ 106.14	$ 109.35
99204	Office/outpatient visit new	2.60	2.10	1.12	0.24	4.94	3.96	XXX	$32.26	$ 159.37	$ 167.09
99205	Office/outpatient visit new	3.50	2.71	1.57	0.32	6.53	5.39	XXX	$32.26	$ 210.66	$ 211.12
99211	Office/outpatient visit est	0.18	0.50	0.08	0.01	0.69	0.27	XXX	$32.26	$ 22.26	$ 23.46
99212	Office/outpatient visit est	0.70	0.91	0.29	0.07	1.68	1.06	XXX	$32.26	$ 54.20	$ 46.19
99213	Office/outpatient visit est	1.30	1.29	0.56	0.10	2.69	1.96	XXX	$32.26	$ 86.78	$ 76.15
99214	Office/outpatient visit est	1.92	1.76	0.84	0.13	3.81	2.89	XXX	$32.26	$ 122.91	$ 110.43
99215	Office/outpatient visit est	2.80	2.33	1.26	0.21	5.34	4.27	XXX	$32.26	$ 172.27	$ 148.33
GPC1X	Complex visit w med care svs	0.33	0.14	0.14	0.02	0.49	0.49	ZZZ	$32.26	$ 15.81	$ -
99417	Prolng off/op e/m ea 15 min	0.61	0.31	0.28	0.05	0.97	0.94	ZZZ	$32.26	$ 31.29	$ -

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*But what **hasn't** changed?*

Summary of CPT Guideline Differences

***CPT 2021 Professional Edition*, American Medical Association**

Component(s) for Code Selection	Office or Other Outpatient Services *99202 - 99215*	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care, Home)
History and Examination	As medically appropriate Not used in code selection	Use key components (history, examination, MDM)
Medical Decision Making (MDM)	May use MDM or total time on the date of the encounter	Use key components (history, examination, MDM)
Time	May use MDM or total time on the date of the encounter	May use face-to-face time or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates the service *Time is NOT a descriptive component for the emergency department levels of E/M services.*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality of patient management	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality

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There will be two systems for E/M code selection and documentation.....

Office or other outpatient E/M visits (99202 – 99215)…. Changing to the *NEW* system

Other E/M services…. Continue with the old system

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Components of E/M Level Selection

Seven components used in descriptors of many E/M codes

- First three are "key components": History; Examination; Medical decision making (MDM)
- Next three are contributory factors (when applicable): Counseling; Coordination of care; Nature of presenting problem
- Final: Time

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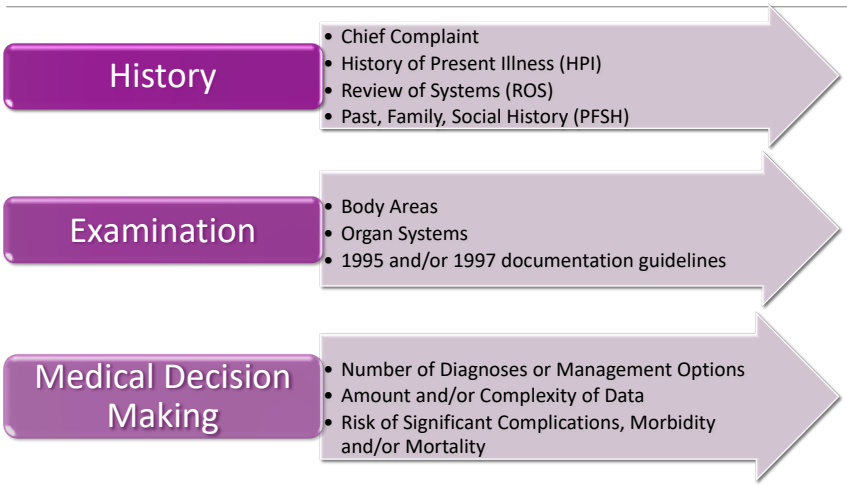
Key Components for Coding Non-Office/ Outpatient Services



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Time for Counseling and/or Coordination of Care

- When counseling and/or coordination of care dominates (>50%) of the physician/patient and/or family encounter (face-to-face time in the office or other outpatient setting, floor/unit time in the hospital or nursing facility), **time** is considered the key or controlling factor to qualify for a particular level of E/M service.
- If the level of service is reported based on counseling and/or coordination of care, you should document the total length of time of the encounter and the record should describe the counseling and/or activities to coordinate care.
- CPT books list *average* time guidelines for a variety of E/M services. These times include work done before, during and after the encounter.

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Resources

Medicare

- https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf
- FAQs on documenting History
  - https://www.cms.gov/Medicare/Medicare-fee-for-service-payment/physicianfeesched/downloads/e-m-visit-faqs-pfs.pdf
- 1995 documentation guidelines for evaluation and management services
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf
- 1997 documentation guidelines for evaluation and management services
  - https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf

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Resources

AAPC

https://www.aapc.com/evaluation-management/em-codes-changes-2021.aspx#:~:text=The%20MPFS%202020%20final%20rule,outpatient%20E%2FM%20code%20selection

AMA

https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management

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Resources & Educational Opportunities: ASCO Practice Central

ASCO will be providing resources on ASCO Practice Central (practice.asco.org) for the remainder of 2020 and into 2021 to assist with the transition.

ASCO Guide to 2021 Evaluation & Management Changes
https://practice.asco.org/sites/default/files/drupalfiles/2020-10/EMResourcesBookOct2020.pdf

Includes:

- Changes to Evaluation and Management Codes in 2021
- Nine Essential Tips to Prepare Your Practice
- Selecting a Code Based on Time
- New Prolonged Services Code and Other Prolonged Services Changes
- Selecting an E/M code Based on Medical Decision-Making
- Sample Transition Checklist

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Audio Books https://communityoncology.org/mycoa/can-support-network/

- ICD-10-CM — POSTED
- Drug Administration — POSTED
- Drug Billing — POSTED
- E/M Traditional — POSTED
- NPPs/ Split Billing — POSTED
- Revenue Cycle & Benchmarking — POSTED
- Bone Marrow Biopsies & Procedures — October
- CCM — October
- TCM/ACM — October
- Appeals — October
- Telehealth in Oncology 2021 — TBD
- E/M 2021 — November

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Webinars https://communityoncology.org/mycoa/can-support-network/

- 2021 Medicare Proposed rule — POSTED
- E/M 2021 – Staff — November
- E/M 2021 – MDs — December

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Thank you for caring for people with cancer.

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Hot Topics in Reimbursement 2020-2021

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Presentation

Hot Topics In Reimbursement 2020-2021

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AGENDA

- Proposed Physician Fee Schedule Rule for 2021
- Proposed Changes to MIPS for 2021
- Proposed Hospital Outpatient Payment Program Rule 2021
- Coding Changes
  - ICD-10
  - HCPCS
  - CPT
  - Telehealth
- Appendices

Proposed Physician Fee Schedule for 2021

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Web Sites for 2021 Proposed Regulations

- This presentation is based on published rules
  - The Proposed Rules were published on August 3, 2020
  - The Comment Period was until 10/5/2020
  - There will be one month between publication and implementation (possibly)
- Physician Rule: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-p
- Hospital Outpatient Rule: https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-17086.pdf

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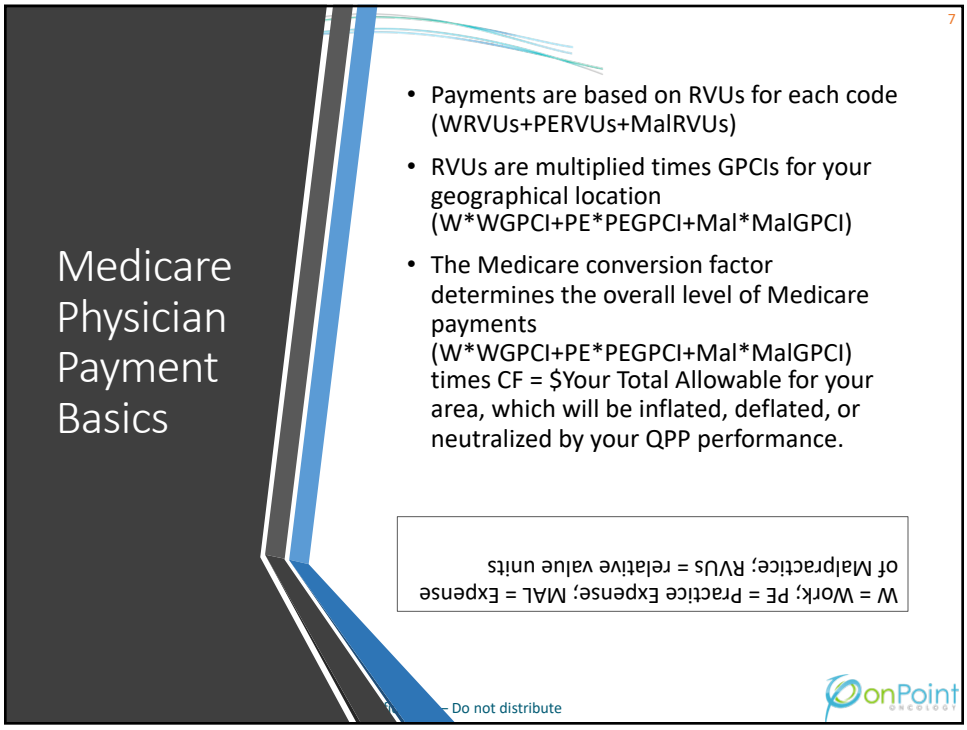
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Medicare Physician Payment Basics
• Payments are based on RVUs for each code (WRVUs+PERVUs+MalRVUs)
• RVUs are multiplied times GPCIs for your geographical location (W*WGPCI+PE*PEGPCI+Mal*MalGPCI)
• The Medicare conversion factor determines the overall 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
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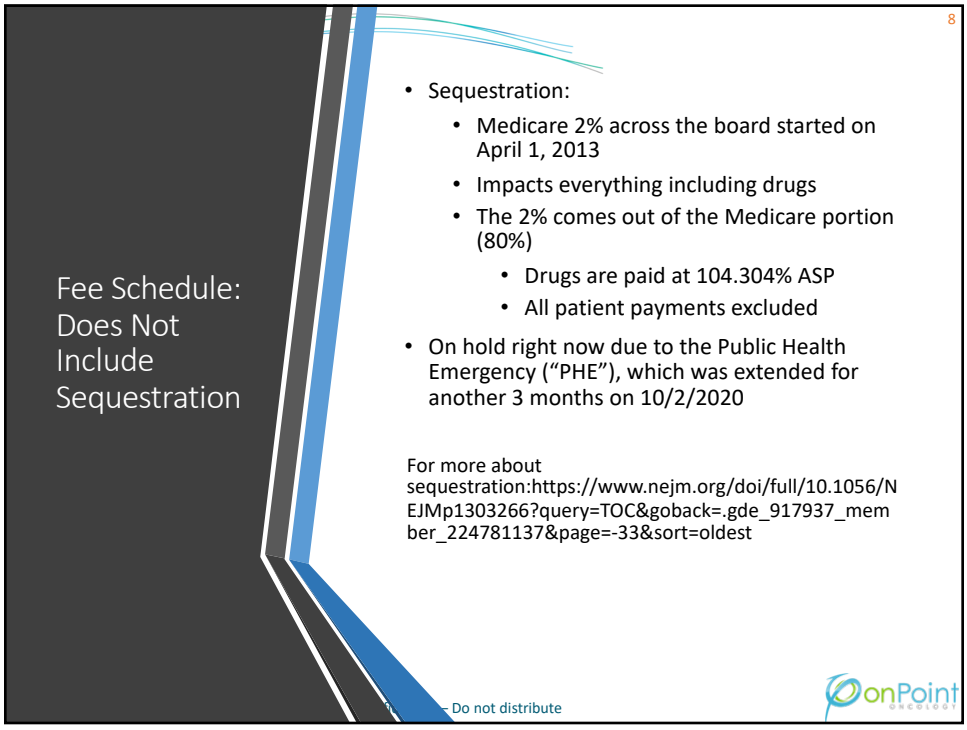
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Fee Schedule: Does Not Include Sequestration
• Sequestration:
• Medicare 2% across the board started on April 1, 2013
• Impacts everything including drugs
• The 2% comes out of the Medicare portion (80%)
• Drugs are paid at 104.304% ASP
• All patient payments excluded
• On hold right now due to the Public Health Emergency ("PHE"), which was extended for another 3 months on 10/2/2020
For more about sequestration:https://www.nejm.org/doi/full/10.1056/NEJMp1303266?query=TOC&goback=.gde_917937_member_224781137&page=-33&sort=oldest
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CONVERSION FACTOR Proposed for 2021

TABLE 88: Calculation of the CY 2021 PFS Conversion Factor

CY 2021 Conversion Factor		36.0896
Statutory Update Factor	0.00 percent (1.0000)	
CY 2021 RVU Budget Neutrality Adjustment	-10.61 percent (0.8939)	
CY 2021 Conversion Factor		**32.2605**

From Table 88, Display Copy PFS, page 894

Impact On Hem-Onc: Proposed Rule 2021

Table 90: Proposed Fee Schedule, Page 898

TABLE 90: CY 2021 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	$246	5%	4%	0%	9%
Anesthesiology	$2,011	-7%	-1%	0%	-8%
Audiologist	$74	-4%	-2%	0%	-7%
Cardiac Surgery	$264	-6%	-2%	-1%	-9%
Cardiology	$6,849	1%	0%	0%	1%
Chiropractor	$759	-7%	-3%	0%	-10%
Clinical Psychologist	$824	-1%	1%	0%	0%
Clinical Social Worker	$851	-1%	1%	0%	0%
Colon And Rectal Surgery	$168	-4%	-1%	0%	-5%
Critical Care	$376	-6%	-2%	0%	-8%
Dermatology	$3,758	-1%	-1%	0%	-2%
Diagnostic Testing Facility	$813	-1%	-5%	0%	-6%
Emergency Medicine	$3,065	-5%	-1%	0%	-6%
Endocrinology	$506	11%	6%	1%	17%
Family Practice	$5,982	9%	4%	1%	13%
Gastroenterology	$1,749	-3%	-1%	0%	-5%
General Practice	$405	5%	2%	0%	8%
General Surgery	$2,041	-4%	-2%	0%	-7%
Geriatrics	$190	2%	2%	0%	4%
Hand Surgery	$245	-2%	-1%	0%	-3%
Hematology/Oncology	$1,702	9%	5%	1%	14%
Independent Laboratory	$639	-3%	-2%	0%	-5%
Infectious Disease	$653	-4%	-1%	0%	-4%
Internal Medicine	$10,654	2%	2%	0%	4%
Interventional Pain Mgmt	$932	4%	3%	0%	7%
Interventional Radiology	$497	-3%	-5%	0%	-9%
Multispecialty Clinic/Other Phys	$152	-3%	-1%	0%	-4%
Nephrology	$2,213	4%	2%	0%	6%
Neurology	$3,513	3%	2%	0%	6%

E/M Values 2020 Versus 2021

CPT[1]/ HCPCS	Description	Work RVUs[2]	Non-Facility PE RVUs[2]	Facility PE RVUs[2]	Mal-Practice RVUs[2]	Total Non-Facility RVUs[2]	Total Facility RVUs[2]	Global	Conversion Factor	2021 Office Price	2020 Office Price
99202	Office/outpatient visit new	0.93	1.12	0.41	0.09	2.14	1.43	XXX	$32.26	$ 69.04	$ 77.23
99203	Office/outpatient visit new	1.60	1.54	0.67	0.15	3.29	2.42	XXX	$32.26	$ 106.14	$ 109.35
99204	Office/outpatient visit new	2.60	2.10	1.12	0.24	4.94	3.96	XXX	$32.26	$ 159.37	$ 167.09
99205	Office/outpatient visit new	3.50	2.71	1.57	0.32	6.53	5.39	XXX	$32.26	$ 210.66	$ 211.12
99211	Office/outpatient visit est	0.18	0.50	0.08	0.01	0.69	0.27	XXX	$32.26	$ 22.26	$ 23.46
99212	Office/outpatient visit est	0.70	0.91	0.29	0.07	1.68	1.06	XXX	$32.26	$ 54.20	$ 46.19
99213	Office/outpatient visit est	1.30	1.29	0.56	0.10	2.69	1.96	XXX	$32.26	$ 86.78	$ 76.15
99214	Office/outpatient visit est	1.92	1.76	0.84	0.13	3.81	2.89	XXX	$32.26	$ 122.91	$ 110.43
99215	Office/outpatient visit est	2.80	2.33	1.26	0.21	5.34	4.27	XXX	$32.26	$ 172.27	$ 148.33
GPC1X	Complex visit w med care svs	0.33	0.14	0.14	0.02	0.49	0.49	ZZZ	$32.26	$ 15.81	$ -
99xxx	Prolng off/op e/m ea 15 min	0.61	0.31	0.28	0.05	0.97	0.94	ZZZ	$32.26	$ 31.29	$ -

Projection Model 2021—Proposed Rule

Code	Payer	Claim Count	Price 2020	Price 2021	Price 2021 w/add-on	Total 2020	Total 2021 Without Add-on	Total 2021 With Add on
99201	Medicare	147	$46	$0	$0	$ 6,834.03	$ -	$ -
99202	Medicare	1296	$77	$69	$85	$ 100,090.08	$ 89,472.56	$ 104,839.88
99203	Medicare	13429	$109	$106	$122	$ 1,468,461.15	$ 1,425,314.38	$ 1,584,548.74
99204	Medicare	52305	$167	$159	$175	$ 8,739,642.45	$ 8,335,684.14	$ 8,955,890.67
99205	Medicare	65013	$211	$211	$226	$ 13,725,544.56	$ 13,695,707.82	$ 14,466,599.47
TOTAL						**$ 24,040,572.27**	**$ 23,546,178.89**	**$ 25,111,878.77**
99211	Medicare	56282	$23	$22	$38	$ 1,320,375.72	$ 1,252,822.97	$ 1,920,186.78
99212	Medicare	27655	$48	$54	$70	$ 1,277,384.45	$ 1,498,835.73	$ 1,826,754.90
99213	Medicare	55688	$76	$87	$103	$ 42,315,641.20	$ 48,223,018.63	$ 54,812,089.09
99214	Medicare	94924	$110	$123	$139	$ 104,458,387.32	$ 116,265,888.38	$ 127,482,182.21
99215	Medicare	131949	$148	$172	$188	$ 19,871,995.17	$ 22,730,995.42	$ 24,295,580.68
TOTAL						**$ 168,943,783.86**	**$ 189,971,561.12**	**$ 210,336,793.66**
					Total All Codes	**$ 192,984,356.13**	**$ 213,517,740.02**	**$ 235,448,672.43**
99xxx		196962			$ 31.29		**$ 585,529.63**	**$ 585,529.63**
Total with 99xxx							**$ 214,103,269.65**	**$ 236,034,202.06**

Assumptions	
Percentage of patients with Add-on	75%
Price of GPC1X	$ 15.81
Price of 99xxx	$ 31.29
Percentage of 99xxx	9.50%

Assumes 75% of patients will have GPC1X add-on
9.5% of extended services added on to Level 5

Projection Model 2021—Proposed Rule

Code	Payer	Claim Count	Price 2020	Price 2021	Price 2021 w/add-on
99201	Medicare	147	$46	$0	$0
99202	Medicare	1296	$77	$69	$85
99203	Medicare	13429	$109	$106	$122
99204	Medicare	52305	$167	$159	$175
99205	Medicare	65013	$211	$211	$226
TOTAL					
99211	Medicare	56282	$23	$22	$38
99212	Medicare	27655	$46	$54	$70
99213	Medicare	555688	$76	$87	$103
99214	Medicare	945924	$110	$123	$139
99215	Medicare	131949	$148	$172	$188
TOTAL					
					Total All Codes
99xxx		196962			$ 31.29
Total with 99xxx					

	Total 2021 Without Add-on	Total 2021 With Add on
,834.03	$ -	$ -
,090.08	$ 89,472.56	$ 104,839.88
,461.15	$ 1,425,314.38	$ 1,584,548.74
,642.45	$ 8,335,684.14	$ 8,955,890.67
,544.56	$ 13,695,707.82	$ 14,466,599.47
,572.27	**$ 23,546,178.89**	**$ 25,111,878.77**
,375.72	$ 1,252,822.97	$ 1,920,186.78
,384.45	$ 1,498,835.73	$ 1,826,754.90
,641.20	$ 48,223,018.63	$ 54,812,089.09
,387.32	$ 116,265,888.38	$ 127,482,182.21
,995.17	$ 22,730,995.42	$ 24,295,580.68
,783.86	**$ 189,971,561.12**	**$ 210,336,793.66**
,356.13	**$ 213,517,740.02**	**$ 235,448,672.43**
	$ 585,529.63	**$ 585,529.63**
	$ 214,103,269.65	**$ 236,034,202.06**

Assumes 75% of patients will have GPC1X add-on
9.5% of extended services added on to Level 5

Part B Physician Drug Changes 2021-- Proposed

- No ASP changes this year so far. But there are Executive Orders, which manufacturers may respond to.
- 505(b)(2) drugs may go into generic drug HCPCS codes if they have similar labeling—major ingredient, route, dosing, indications, etc.
  - No mention of current drugs in single J-codes
  - This is an established pathway

Appropriate Use Criteria for Advanced Imaging

- **NOTICE: The EDUCATIONAL AND OPERATIONS TESTING PERIOD for the AUC Program has been extended through CY 2021. There are no payment consequences associated with the AUC program during CY 2020 and CY 2021. CMS encourages stakeholders to use this period to learn, test and prepare for the AUC program.**

Appropriate Use Criteria Timeline

- Currently, the program is set to be fully implemented on January 1, 2022 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 operates 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 1/1/22. .
- 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

Telehealth Services—Additions for 2021--Proposed

Changes to the Medicare telehealth services list are made with the annual MPFS rulemaking process. When a request to add a service to the list is submitted, Medicare assigns it to one of two categories. Category 1 is for services similar to consultations and office visits currently on the list, and Category 2 is for services that are not similar to those currently on the list. CMS proposes to add the following services to the list on a Category 1 basis:

- Group Psychotherapy (Common Procedural Technology or CPT code 90853)
- Domiciliary, Rest Home or Custodial Care Services, Established Patient (CPT codes 99334-99335)
- Home Visits, Established Patient (CPT codes 99347- 99348)
- Cognitive Assessment and Care Planning Services (CPT code 99483)
- Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS code GPC1X)
- Prolonged Services (CPT code 99XXX)
- Psychological and Neuropsychological Testing (CPT code 96121)

Page 82, Display Copy, Proposed Rule

Temporary Telehealth Services—Additions for 2021--Proposed

- For the services that CMS **does not permanently** add to the Medicare telehealth list, CMS proposes to create a temporary Category 3. This will allow the agency to collect public comments on whether to add these services permanently in future PFS annual rulemaking. These services were added during the PHE, which will remain on the list through the calendar year in which the PHE ends.
- CMS is proposing to add the following services to Medicare telehealth list on a Category 3 basis:
  - Domiciliary, Rest Home or Custodial Care services, Established Patients (CPT codes 99336-99337)
  - Home Visits, Established Patient (CPT codes 99349-99350)
  - Emergency Department Visits, Levels 1-3 (CPT codes 99281-99283)
  - Nursing facilities discharge day management (CPT codes 99315-99316)
  - Psychological and Neuropsychological Testing (CPT codes 96130-96133)

Page 82, Display Copy, Proposed Rule

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What About Telephone ONLY Services?

- CMS notes that they are not proposing to continue payment for audio-only telephone visits beyond the PHE.
- After the conclusion of the PHE, telehealth services will once again be required to be furnished using an interactive two-way video and audio telecommunications system.
- However, CMS is seeking comments on whether the audio-only services should be made permanent or whether CMS should develop coding and payment for a similar virtual check-in for a longer unit of time. Notably, discontinuing coverage of audio-only visits runs against recent trends at the state level.

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Teaching Physicians

- CMS proposes to allow physicians teaching residents in a teaching hospital to use telehealth technology to provide the direction, management and review that is required.
- The rule also proposes expanded billing flexibilities for residents providing services in an inpatient setting at a teaching hospital.
  - These include higher-level E/M visits and services to Medicare beneficiaries that are otherwise outside the scope of the Graduate Medical Education (GME) program.
  - CMS is asking for comments on the proposal to include whether these flexibilities should be temporary through the end of the PHE or should be made permanent.

Proposed Rule Display Copy, Page 367-368

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More Telehealth—CMS Wants Your Input on:

- **Removal of Frequency Limitations for Subsequent Skilled Nursing Facility (SNF)**
  - CMS seeks comment on whether it would enhance patient access to care to remove frequency limitations for subsequent nursing facility visits furnished via Medicare telehealth altogether, and how best to ensure that patients would continue to receive necessary in-person care.
- **Expanded Virtual Check-In**
  - CMS seeks comment on whether the agency should develop coding and payment for a service similar to the virtual check-in but for a more extended unit of time and subsequently with a higher value. CMS also seeks input on the duration of the services, the resources in both work and practice expense (PE) associated with furnishing this service, and whether this should be a provisional or permanent policy

Proposed Rule Display Copy, Page 367-368

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Review of Remote Physiological Monitoring

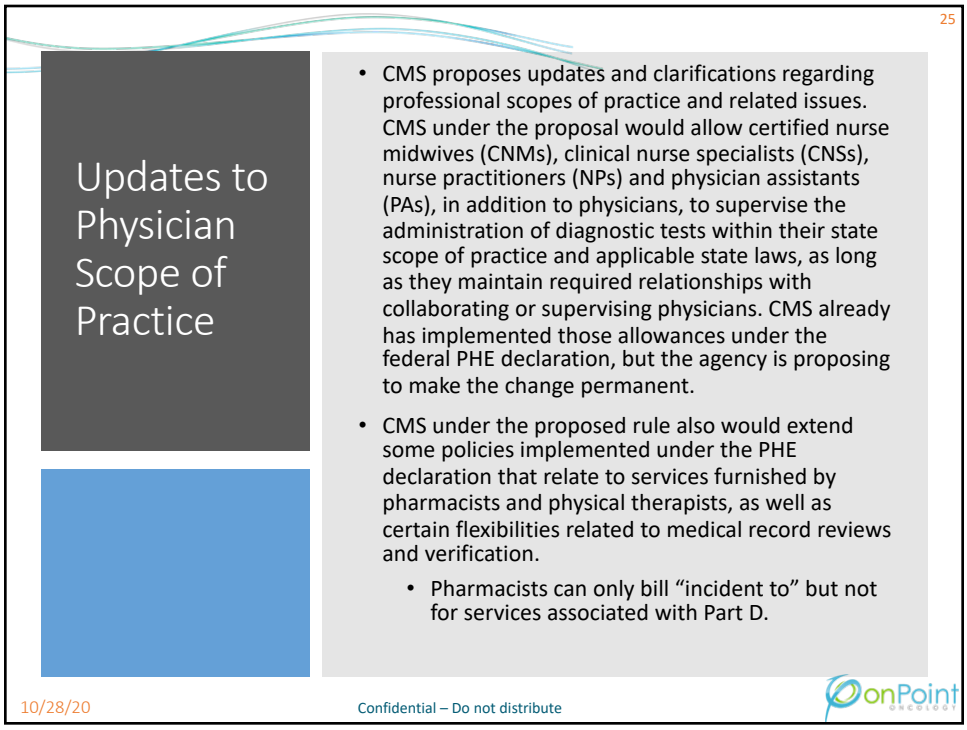
- In the PFS proposed rule, CMS finally proposes to resolve several of the payment puzzles that have troubled clinicians and technology companies for the last few years. The rule provides a code-by-code walkthrough of the RPM process:
  - 99453 for the clinical staff time needed for patient set up and education on the RPM device;
  - 99454 for the device supply with daily recording for a 30-day period; (the older)
  - 99091 for a professional's analysis and interpretation of the digitally stored and transmitted data for a minimum of 30 minutes each 30 days; and
  - 99457 for treatment planning and management through interactive communication with the patient for at least 20 minutes per month
  - (with the possibility of 99458 for additional 20-minute increments of such treatment management).
- Under the proposed rule, devices used for RPM and billed under 99453 would need to (i) meet the FDA definition of a "medical device" as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act (but not necessarily be cleared by the FDA or ordered by a prescriber); (ii) automatically digitally collect physiological data (not just permit patient self-reporting); and (iii) generate "reliable and valid physiologic data that allow understanding of a patient's health status to develop and manage a plan of treatment."
- RPM would be billable in acute-care contexts, not just chronic care management as suggested in some materials. Care planning would be reimbursable (under 99457 and possibly 99458) whether performed by a physician or by clinical staff under a physician's general supervision, but only if it involved "a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission."

Changes to Remote Physiologic Monitoring

- CMS proposes to clarify Medicare payment policies for certain remote physiologic monitoring (RPM) services. For example, the agency proposed clarifying that:
  - CMS considers RPM services to be evaluation and management (E/M) services; really cannot conclude if this is good or bad…
  - CMS will again require that an established patient-physician relationship already exist for RPM services to qualify for Medicare coverage once the PHE declaration ends;
  - Only non-physician practitioners (NPPs) and physicians eligible to provide E/M services are eligible to bill Medicare for RPM services
  - Qualifying clinicians may provide RPM services to patients with acute conditions and those with chronic conditions

Changes to Remote Physiologic Monitoring

- CMS also proposed permanently adopting two clarifications to RPM services that the agency had implemented under the federally declared PHE. These are:
  - allowing auxiliary personnel, including contracted employees, to provide certain RPM services if they are under a physician's supervision
  - allowing providers to obtain patients' consent at the time RPM services are furnished
- In addition, CMS said it is seeking public comment on whether current RPM codes accurately capture the full scope of clinical scenarios in which RPM services may benefit Medicare beneficiaries.
- CMS also is seeking comments on how RPM services are used in clinical practice and how they might be coded, billed and valued under the Medicare PFS.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Updates to Physician Scope of Practice
• CMS proposes updates and clarifications regarding professional scopes of practice and related issues. CMS under the proposal would allow certified nurse midwives (CNMs), clinical nurse specialists (CNSs), nurse practitioners (NPs) and physician assistants (PAs), in addition to physicians, to supervise the administration of diagnostic tests within their state scope of practice and applicable state laws, as long as they maintain required relationships with collaborating or supervising physicians. CMS already has implemented those allowances under the federal PHE declaration, but the agency is proposing to make the change permanent.
• CMS under the proposed rule also would extend some policies implemented under the PHE declaration that relate to services furnished by pharmacists and physical therapists, as well as certain flexibilities related to medical record reviews and verification.
• Pharmacists can only bill "incident to" but not for services associated with Part D.
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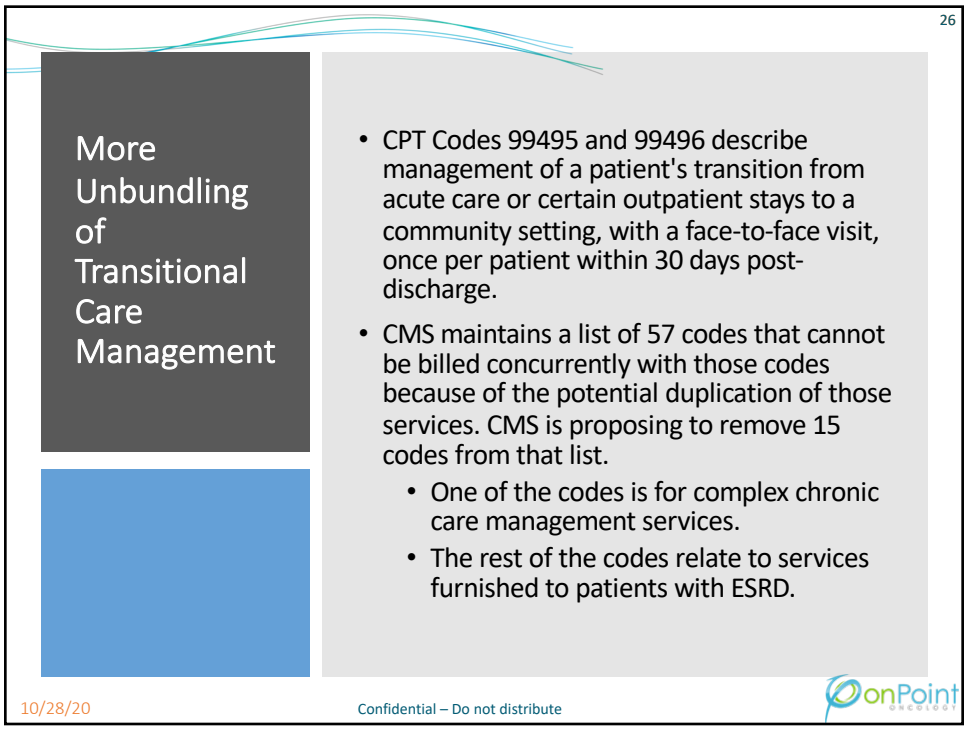
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More Unbundling of Transitional Care Management
• CPT Codes 99495 and 99496 describe management of a patient's transition from acute care or certain outpatient stays to a community setting, with a face-to-face visit, once per patient within 30 days post-discharge.
• CMS maintains a list of 57 codes that cannot be billed concurrently with those codes because of the potential duplication of those services. CMS is proposing to remove 15 codes from that list.
• One of the codes is for complex chronic care management services.
• The rest of the codes relate to services furnished to patients with ESRD.
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Changes to Transitional Care Management for 2021

- CMS is proposing unbundled these codes in 2021
- You may also bill 99490-99491 with these codes

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 (PI 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.

Removal of Outdated National Coverage Decisions

- CMS seeks comments on its proposal to remove nine NCDs. CMS believes that these NCDs may no longer contain pertinent or clinically relevant information and are rarely used by beneficiaries.
- The NCDs are
  - Extracorporeal Immunoadsorption (ECI) using A Columns;
  - Electrosleep Therapy;
  - Implantation of Gastroesophageal Reflux Device;
  - Apheresis (Therapeutic Pheresis);
  - Abarelix for the Treatment of Prostate Cancer;
  - Histocompatibility Testing; Cytogenetic Studies;
  - Magnetic Resonance Spectroscopy; and
  - FDG PET for Inflation and Infection.

A Brief Word About Future E/M Services

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

More later!!!

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THE QPP & MIPS Proposed RULE for 2021 From CMS' Presentation 8/12/2020

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Quality Payment Program

The Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) requires CMS by law to implement an incentive program, referred to as the Quality Payment Program, that provides 2 participation tracks:

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Alternative Payment Models (APMs)

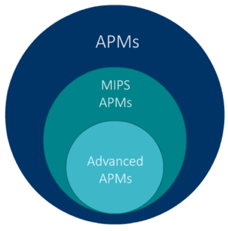
Overview

- APMs reward healthcare providers for delivering value-based care. They can apply to a specific:
  - Health condition, like end-stage renal disease
  - Care episode, like joint replacement
  - Population, like primary care providers in Maryland

Types of APMs

- APMs
- Advanced APMs
- MIPS APMs

Please note: The designation of the APM does not affect a clinician's eligibility for MIPS. APM participants will still need to participate in MIPS unless they receive QP status or are otherwise exempt.



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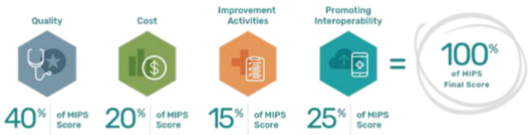
Merit-based Incentive Payment System (MIPS)

Quick Overview

MIPS 2021 Proposed Performance Categories



*Revised weights according to the 2021 Proposed Rule

- Comprised of 4 performance categories.
- So what? *The points from each performance category are added together to give you a MIPS Final Score.*
- The MIPS Final Score is compared to the MIPS performance threshold to determine if you receive a positive, negative, or neutral payment adjustment

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2021 MIPS Proposed Changes

MIPS Participation and Reporting

2020 Final	2021 Proposed
MIPS eligible cliniciansmay participate in MIPS as: • An individual clinician • A group • A virtual group Eligible clinicians in a MIPS APM participate in MIPS through their APM Entity under the APM Scoring Standard	MIPS eligible clinicians may participate in MIPS as: • An individual clinician • A group • A virtual group • An APM Entity CMS would sunset the APM Scoring Standard beginning with the 2021 performance period. CMS is proposing a new APM Performance Pathway (APP). The APP will be discussed as part of the MIPS APM Proposals.

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2021 APMs Proposed Rule Changes

APM Performance Pathway (APP)

We have also proposed a new APM Performance Pathway (APP)beginning with the 2021 performance year - a predictable and consistent MIPS reporting standard. The APP would be:

- Only available to MIPS APMs participants
- Reported by the individual eligible clinician, group (TIN), or APM Entity
  - *CMS will award the highest available score*
- Complementary to MVPs

Participation is optional: MIPS APM participants have the option to participate in MIPS via the APP.

ACOs: ACOs participating in the Medicare Shared Savings Program would be required to report through the APP for purposes of assessing their quality performance for that program, but MIPS eligible clinicians participating in these ACOs also would have the option of reporting outside the APP.

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2021 APMs Proposed Rule Changes

APM Performance Pathway (APP)

Similar to MVPs, the APP will be composed of a fixed set of measures for each performance category.

Performance Category	Proposed Weights	Proposed Changes
Quality	50%	• Composed of 6 population health measuresthat are available to all MIPS APM participants • Measures reported through the APP would be automatically used for Shared Savings Program (SSP) quality scoringto satisfy reporting requirements
Cost	0%	• Reweighted to 0to align with MIPS APM current responsibilities
Improvement Activities	20%	• Score would be automatically assignedbased on the requirements of participants' MIPS APMs • In 2021, all APM participants reporting through the APP will earn of a score of 100%
Promoting Interoperability	30%	• Reported and scored at the individual or group level as required for the rest of MIPS

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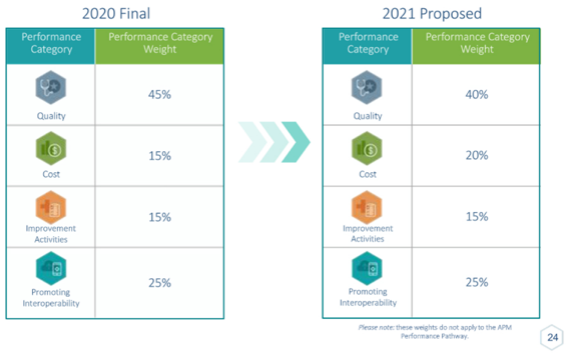
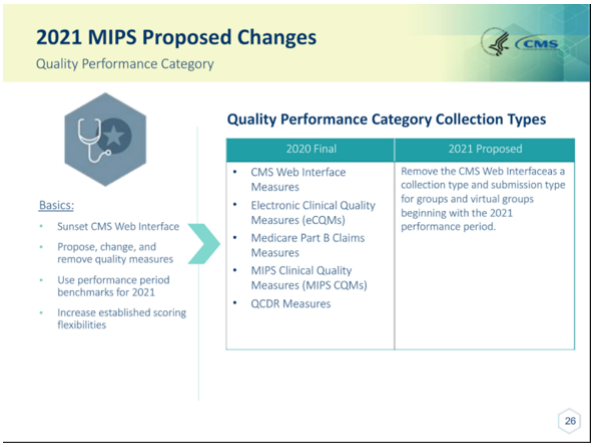
2021 MIPS Proposed Changes

Performance Category Weights



2021 MIPS Proposed Changes

Quality Performance Category



2021 MIPS Proposed Changes

Quality Performance Category

Basics:

- Sunset CMS Web Interface
- Propose, change, and remove quality measures
- Use performance period benchmarks for 2021
- Increase established scoring flexibilities

Quality Measures:

We are proposing a total of *206 quality measures* which reflect proposals on:

- Substantive changes to 112 existing MIPS quality measures
- Changes to specialty sets
- Removal of measures from specific specialty sets
- Removal of 14 quality measures and the addition of the following 2 administrative claims outcome quality measures:
  - Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS Eligible Clinician Groups(to replace the current All-Cause Readmission measure)
  - Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS eligible clinicians

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2021 MIPS Proposed Changes

Quality Performance Category

Basics:

- Sunset CMS Web Interface
- Propose, change, and remove quality measures
- Use performance period benchmarks for 2021
- Increase established scoring flexibilities

Scoring Flexibilities

2020 Final	2021 Proposed
• For measures with significant ICD-10 coding changes, we truncated the performance period to the first 9 months of the calendar year. • For measures with significant changes to clinical practice guidelines, we suppressed the measure from scoring (0 achievement points and total measure achievement points reduced by 10).	Increase previously established scoring flexibility by: • Expanding reasons that a quality measure may be impacted, and • Revising when to allow scoring of the measure with a performance period truncation (to 9 months) or the complete suppression of the measure

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2021 MIPS Proposed Changes

Cost Performance Category

Basics:

- *No changes* to existing measures:
  - TPCC measure
  - MSPB Clinician measure
  - 18 episode-based cost measures
- *No changes* to measure attribution
- *Proposed:* updating measure specifications to include telehealth services

Measures:

2020 Final	2021 Proposed
Measures: • Total Per Capita Cost (TPCC) measure (Revised) • Medicare Spending Per Beneficiary - Clinician (MSPB-C) measure (Name and specification Revised) • 8 existing episode-based measures • Added 10 new episode-based measures	• Adding telehealth services directly applicable to existing episode-based cost measures and TPCC measure • Updated specifications available for review on the MACRA feedback page

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2021 MIPS Proposed Changes

Improvement Activities Performance Category

Basics:

- Minimal Inventory updates proposed
- Establish policies in relation to the Annual Call for Activities for nominating new improvement activities
- Establish a process for agency-nominated improvement activities

Criteria and Pathway for Nominating a New Improvement Activity:

Proposed Criteria Changes:

- Establish 1 new criterion for nominating new improvement activities beginning with the 2021 performance period and future years:
  - Include activities which can be linked to existing and related MIPS quality and cost measures, as applicable and feasible

Proposed Nomination Option Changes:

- Allow nomination of improvement activities in addition to the Annual Call for Activities in 2 circumstances:
  1. An exception to the nomination period timeframe during a public health emergency
  2. A process for agency-nominated improvement activities

To review the entire set of current criteria for nominating a new Improvement Activity, please refer to the 2021 Quality Payment Program Proposed Rule Fact Sheet

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2021 MIPS Proposed Changes

Promoting Interoperability Performance Category

Basics:

- Retain the Query of Prescription Drug Monitoring Program (PDMP) measure as an optional measure
- Change measure name and add an optional Health Information Exchange bi-directional exchange measure
- CEHRT flexibility

Objectives and Measures:

2020 Final	2021 Proposed
Beginning with the 2020 performance period: • Remove the Verify Opioid Treatment Agreement measure • Include the Query of PDMP measure as optional with yes/no response	• Retain the Query of PDMP measure as an optional measure increasing its worth from 5 to 10 bonus points • Change the name of the Support Electronic Referral Loops by Receiving and Incorporating Health Information by replacing "incorporating" with "reconciling" • Add an optional Health Information Exchange (HIE) bi-directional exchange measure

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2021 MIPS Proposed Changes

Promoting Interoperability Performance Category

Health Information Exchange (HIE) Bi-directional Exchange Measure

We are proposing to add a Health Information Exchange (HIE) Bi-directional Exchange measure, which would be:

- Worth 40 points
- An optional alternative to the 2 existing measures - clinicians may report either the new HIE measure OR the 2 existing measures
- Reported by attestation with a yes/no response:

- I participate in an HIE to enable secure, bi-directional exchange to occur for every patient encounter, for every patient transition or referral, and record stored or maintained in the EHR during the performance period.

- The HIE that I participate in is capable of exchanging information across broad network of unaffiliated exchange partners including those using disparate electronic health records (EHRs); and does not engage in exclusionary behavior when determining exchange partners.

- I use the functions of Certified EHR Technology (CEHRT) for this measure, which may include technology certified to criteria at 45 CFR 170.315(b)(1), (b)(2), (g)(8), or (g)(10).

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2021 MIPS Proposed Changes

Promoting Interoperability Performance Category

Updates to CEHRT Due to the 21st Century Cures Act Final Rule

- The 2015 Edition Cures update includes:
  - Changes to technical standards, such as e-prescribing
  - Technical updates to the 2015 Edition functionality, such as moving from Common Clinical Data Sets (CCDS) to the US Core Data for Interoperability (USCDI)
- Healthcare providers have until August 2, 2022 to adopt these changes
  - This timeline includes 3 months of enforcement discretion currently in place
- We are proposing to *allow* healthcare providers the flexibility to use the current version or the updated version until the August 2, 2022 deadline

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2021 MIPS Proposed Changes

Third-Party Intermediaries

Data Validation

CMS is proposing the following additional factors for data validation:

- QCDRs and Qualified Registries conduct data validation audits, with specific obligations, on an annual basis
- QCDRs and Qualified Registries conduct an additional targeted audit if errors are identified during the data validation audit

We are seeking comment on whether we should require Health IT Vendors to perform data validation. Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey vendors currently perform a type of data validation, but we are requesting comment on whether the CAHPS survey vendors data validation process should align with that required of QCDRs and Qualified Registries.

Approval Criteria

CMS is proposing the following additional factors for consideration when determining whether to approve a third-party intermediary for future participation in the MIPS program:

- The entity's compliance with the requirements for any prior MIPS performance period for which it was approved as a third party intermediary
- Whether the entity provided inaccurate information to the clinicians regarding MIPS program requirements.

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2021 MIPS Proposed Changes

Third-Party Intermediaries

Data Submission

- No changes the performance category data submission requirements finalized in the CY 2020 PFS Final Rule
- Allow QCDRs, Qualified Registries, and Health IT Vendors to support data submission for
  - the APM Performance Pathwaybeginning with the 2021 performance period
  - MVPs beginning with the 2022 performance period *(Note: health IT vendors can only support MVPs if they support the Quality, IA, and PI performance categories)*

Remedial Action and Termination Processes:

Providing additional guidance on what would be required in a corrective action plan (CAP):

- The CAP must detail the issues that contributed to the non-compliance
- The CAP must detail the impact to individual clinicians, groups, or virtual groups, regardless of how they are participating in the program
- The CAP must detail the corrective actions implemented by the third party intermediary to ensure that the non-compliance issues have been resolved and will not reoccur in the future
- The CAP must include a detailed timeline for achieving compliance with the applicable requirements

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2021 MIPS Proposed Changes

Complex Patient Bonus

2020 Final	Proposed
Existing policy: • Clinicians, groups, virtual groups, and APM Entities can earn up to 5 bonus points to offset the complexity of their patient population	For the 2020 performance period only: • CMS is proposing to double the complex patient bonus: • Clinicians, groups, virtual groups, and APM Entities can earn up to 10 bonus points to account for the additional complexity of treating their patient population due to COVID-19

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2021 MIPS Proposed Changes

Extreme and Uncontrollable Circumstances Exception Application

2020 Final	2021 Proposed
Individual clinicians, groups and virtual groups can submit an application to reweight 1 or more MIPS performance categories due to extreme and uncontrollable circumstances, outside the clinician's control, that either: • Prevents them collecting data for a sustained period, or • Could impact performance on cost measures Data submission would override approved reweighting on a category-by-category basis.	*No change* to policy for individual clinicians, groups and virtual groups Beginning with the 2020 performance period: • CMS is proposing to allow APM entities to submit an application to request reweighting of all MIPS performance categories • If the application were approved, the APM Entity would receive a score equal to the performance threshold even if data are submitted. This would apply to all clinicians in the APM Entity *(note: this differs to our policy for individuals, groups, and virtual groups).* - Beginning in 2021, eligible clinicians in an APM Entity could individually earn higher scores

To review comprehensive information on QPP COVID-19 flexibilities please refer to the Quality Payment Program COVID-19 Response Fact Sheet.

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2021 MIPS Proposed Changes

Performance Threshold and Payment Adjustments

2020 Final

Final Score 2020	Payment Adjustment 2022
≥85 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance—minimum of additional 0.5%
45.01-84.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
45 points	• Neutral payment adjustment
11.26-44.99 points	• Negative payment adjustment greater than -9% and less than 0%
0-11.25 points	• Negative payment adjustment of -9%

2021 Proposed

Final Score 2021	Payment Adjustment 2023
≥85 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance—minimum of additional 0.5%
50.01-84.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
50 points	• Neutral payment adjustment
12.51-49.99 points	• Negative payment adjustment greater than -9% and less than 0%
0-12.50 points	• Negative payment adjustment of -9%

2021 Performance Thresholds:
Performance Threshold = 50 points
Additional Performance Threshold = 85 points

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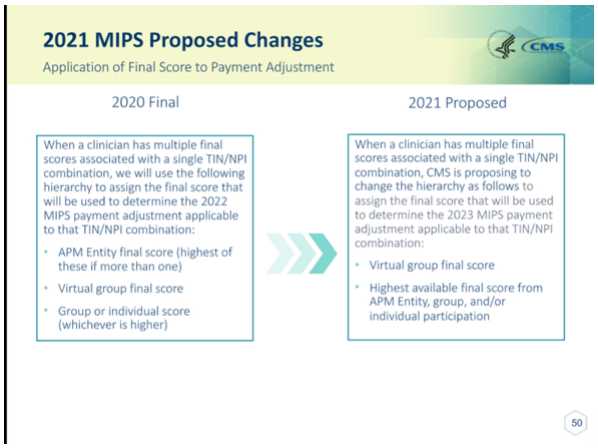

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For Further Information

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

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Proposed Rule Hospital Outpatient Payment 2021

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Comments and Implementation

5 Oct. 2020

Comments on the proposed rules were due by October 5, 2020. Because of the public health emergency (PHE), CMS plans to implement the rule 30 days after it is finalized instead of the standard 60-day period.

The Final Rule will likely be released in early December, providing little time for hospitals to adapt to changes made by the Final Rule before they take effect on January 1, 2021.

early December

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2021 Proposed 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. No increase this year proposed!

Pay non-pass-through drugs and biosimilars acquired under the 340B program at ASP minus 28.7%. CMS has won the latest appeal.

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

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Update on ASP

- In early August 2020, the U.S. Court of Appeals for the District of Columbia Circuit reversed the lower district court's ruling and held that CMS in fact, reasonably interpreted the Medicare statute as authorizing the rate reductions under a "general adjustment authority" with the purpose "to reimburse hospitals for their acquisition costs accurately."
- Based on the results of this survey of hospital acquisition costs for 340B drugs, CMS is now proposing the pay for 340B drugs for CY 2021 and subsequent years at ASP minus 34.7 percent, plus an add-on of 6 percent of the ASP. This results in a net payment rate of ASP minus 28.7 percent for 340B drugs. For biosimilars, CMS is proposing to set net reimbursement at ASP minus 28.7 percent of the biosimilar's ASP, not minus 28.7 percent of the reference product's ASP.
- Like in the previous policy, rural sole community hospitals, PPS-exempt cancer hospitals and children's hospitals are exempt from this lower 340B reimbursement. Wholesale Acquisition Cost (WAC) will be used for products without an ASP available.

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OPPS Payment Update

- CMS proposes an increase of 2.6 percent for OPPS payment rates in CY 2021, which it estimates will result in a total of approximately $83.9 billion in payments to OPPS.
- CMS will continue the statutory 2 percentage point reduction for hospitals failing to meet the hospital outpatient departments (HOPDs) quality-reporting requirements.

Cancer Hospital Payment Adjustment 2021

- CMS proposes to continue to provide additional payments to cancer hospitals, so that a cancer hospital's payment-to-cost ratio (PCR) after the additional payments is equal to the weighted average PCR for the other OPPS hospitals using the most recently submitted or settled cost report data.
- The 21st Century Cures Act requires that this weighted average PCR be reduced by 1 percentage point, the data and the required 1 percentage point reduction requires a proposed target PCR of 0.89 be used to determine the CY 2021 cancer hospital payment adjustment to be paid at cost report settlement.

Elimination of the "Inpatient Only" List

- The Inpatient Only (IPO) List was created to identify services that require inpatient care because of the invasive nature of the procedure, the need for postoperative recovery time or the underlying physical condition of the patient.
- CMS concluded that the list is no longer necessary to identify services that require inpatient care because of changes in medical practice, including new technologies and innovations.
- Beginning with 2021, CMS proposes to eliminate the IPO list over three calendar years, starting with the removal of 300 musculoskeletal-related services in 2021.
  - They are asking for comments on whether three years is an appropriate timeframe for the elimination; any other services that are candidates for removal in CY 2021; and the sequence of removal over the three years.
  - CMS also proposes to continue the two-year exemption from site-of-service claims denials and recovery audit contractor referrals for services removed from the IPO. Given the significant surge in the number of newly removed services because of the proposed elimination of the IPO, CMS requests comments on whether the two-year exemption is still adequate.

Prior Authorization Proposed in 2021

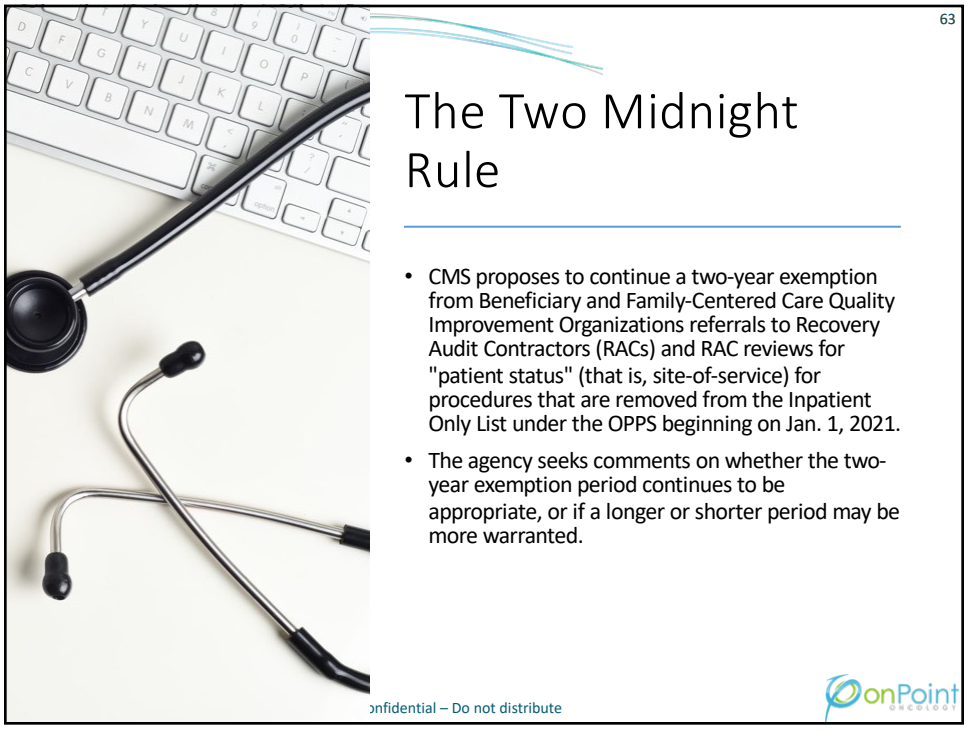
- Last year, CMS finalized a proposal to establish a process through which hospitals must submit a prior authorization request for a provisional affirmation of coverage before a covered outpatient service is furnished to the beneficiary and before the claim is submitted for processing. The change applied to five categories of services: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation.
- This year, the agency proposes to expanded prior authorization requirements for two additional services: cervical fusion with disc removal and implanted spinal neurostimulators to curb unnecessary utilization. Services in these two categories would be subject to prior authorization for dates of service on or after July 1, 2021. CMS estimates annual Medicare savings of more than $31.8 million.
- It is likely that this policy will expand in future rulemakings.

Site Neutral Policy for Clinic Visits

- As finalized in CY2019 OPPS/ASC final rule, CMS completed the 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's office. CMS instituted the proposal based on its authority to restrict unnecessary increases in the volume of covered services.
- In September 2019, a federal district court sided with hospital plaintiffs, ruling that CMS lacked statutory authority to implement the change. However, on July 17, 2020, the U.S. Court of Appeals for the District of Columbia Circuit ruled in favor of CMS, holding that the agency's regulation was a reasonable interpretation of the statutory authority.
- In light of this recent court ruling, CMS will continue the site-neutral policy in 2021. CMS has not released information on how or whether it will address reprocessing 2019 claims that were previously reprocessed at the higher OPPS rate.

PHE Extension of The Pass-through

- CMS is requesting comments on whether pass-through status should be extended for an additional time period because of the effects of COVID-19 on the use of those items with pass-through status.
- CMS is also proposing to clarify that a new medical device is part of the U.S. Food and Drug Administration's (FDA) Breakthrough Devices Program and has received marketing authorization for the indication covered by the Breakthrough Device designation does not need to meet the substantial clinical improvement criterion.


63
The Two Midnight Rule
• CMS proposes to continue a two-year exemption from Beneficiary and Family-Centered Care Quality Improvement Organizations referrals to Recovery Audit Contractors (RACs) and RAC reviews for "patient status" (that is, site-of-service) for procedures that are removed from the Inpatient Only List under the OPPS beginning on Jan. 1, 2021.
• The agency seeks comments on whether the two-year exemption period continues to be appropriate, or if a longer or shorter period may be more warranted.
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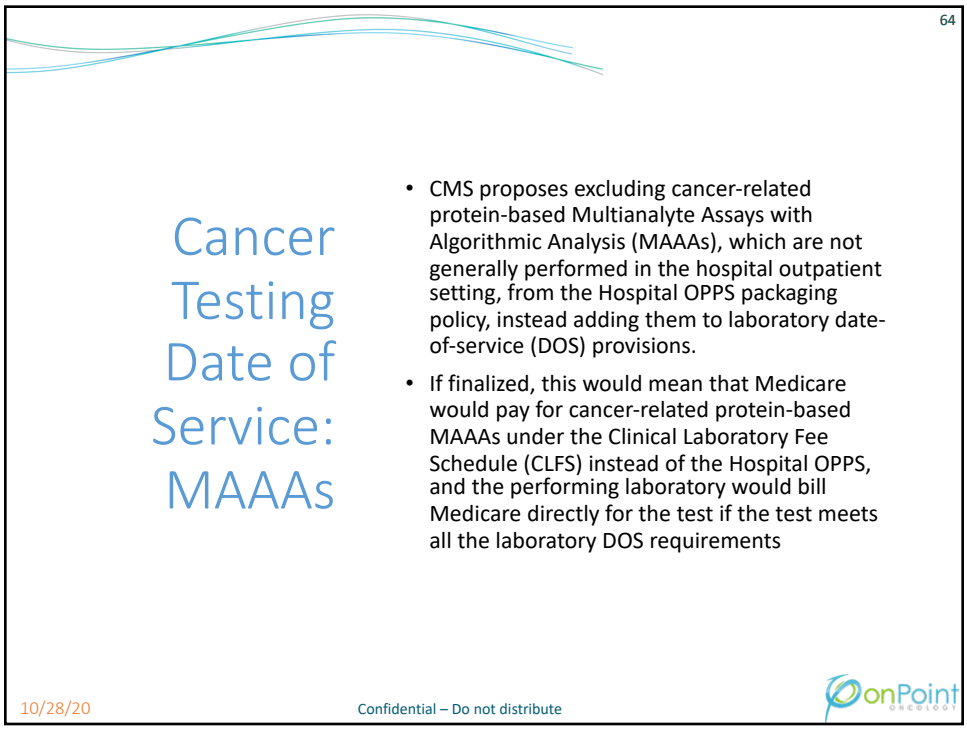
64
Cancer Testing Date of Service: MAAAs
• CMS proposes excluding cancer-related protein-based Multianalyte Assays with Algorithmic Analysis (MAAAs), which are not generally performed in the hospital outpatient setting, from the Hospital OPPS packaging policy, instead adding them to laboratory date-of-service (DOS) provisions.
• If finalized, this would mean that Medicare would pay for cancer-related protein-based MAAAs under the Clinical Laboratory Fee Schedule (CLFS) instead of the Hospital OPPS, and the performing laboratory would bill Medicare directly for the test if the test meets all the laboratory DOS requirements
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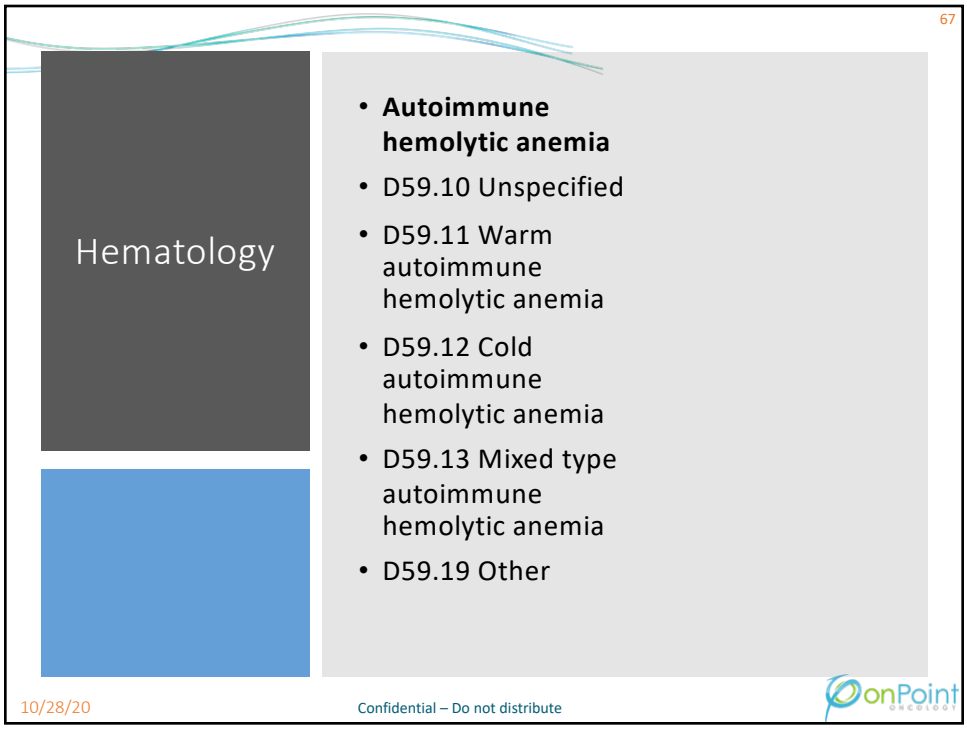
ICD-10-CM Changes for Hem-Onc

OCTOBER 1, 2019

Hematology: Sickle Cell ("SC")

- D57.213 SC/Hb-C Disease with cerebral vascular involvement
- D57.218 SC/Hb-C Disease with crisis with other specified complication
- D57.03 SC/Hb-SS Disease with cerebral vascular involvement
- D57.09 SC/Hb-SS Disease with other specified complication
- D57.413 SC thalassemia, unspecified with cerebral vascular involvement
- D57.418 SC thalassemia, unspecified with crisis with other specified complication
- D57.42 SC thalassemia beta zero without crisis
- D57.431 SC thalassemia beta zero with acute chest syndrome
- D57.432 SC thalassemia beta zero with splenic sequestration
- D57.433 SC thalassemia beta zero with cerebral vascular involvement
- D57.438 SC thalassemia beta zero with crisis with other specified complication

- D57.439 SC thalassemia beta zero with crisis, unspecified
- D57.451 SC thalassemia beta plus with acute chest syndrome
- D57.452 SC thalassemia beta plus with splenic sequestration
- D57.453 SC thalassemia beta plus with cerebral vascular involvement
- D57.44 SC thalassemia beta plus without crisis
- D57.458 SC thalassemia beta plus with crisis with other specified complication
- D57.459 SC thalassemia beta plus with crisis, unspecified
- D57.813 SC disorders, other with cerebral vascular involvement
- D57.818 SC disorders, other with crisis with other specified complication


67
Hematology
• Autoimmune hemolytic anemia
• D59.10 Unspecified
• D59.11 Warm autoimmune hemolytic anemia
• D59.12 Cold autoimmune hemolytic anemia
• D59.13 Mixed type autoimmune hemolytic anemia
• D59.19 Other
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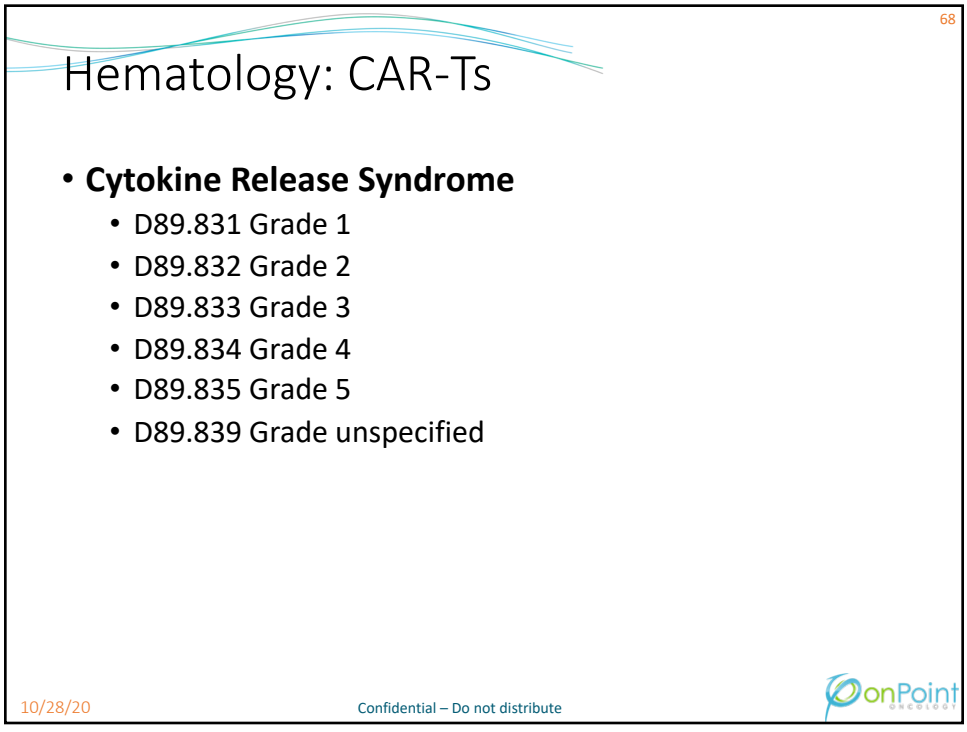
68
Hematology: CAR-Ts
• Cytokine Release Syndrome
• D89.831 Grade 1
• D89.832 Grade 2
• D89.833 Grade 3
• D89.834 Grade 4
• D89.835 Grade 5
• D89.839 Grade unspecified
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Hematology

- Eosinophilia, D72.1- has been expanded into codes such as
  - D72.110, Idiopathic hypereosinophilic syndrome [IHES];
  - D72.111, Lymphocytic variant hypereosinophilic syndrome [LHES];
  - D72.12, Drug rash with eosinophilia and systemic symptoms syndrome, among others.
  - Eosinophilia of the respiratory system (J82.8-) has also been expanded to capture acute or chronic Eosinophilic pneumonia or Eosinophilic asthma.
- Immunodeficiency can now be described as due to drugs (D84.821) or external causes (D84.822).

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Chronic Kidney Disease

- **Chronic Kidney Disease, Stage 3**
  - N18.30 Stage 3,Unspecified
  - N18.31 Stage 3a
  - N18.32 Stage 3b

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New HCPCS Fourth Quarter 2020

Code	Short Description	Long Description
C9060	Fluoroestradiol f18	Fluoroestradiol f18, diagnostic, 1 mci
C9062	Daratumumab hyaluronidase	Injection, daratumumab 10 mg and hyaluronidase-fihj
C9064	Mitomycin pyelocalyceal inst	Mitomycin pyelocalyceal instillation, 1 mg
C9065	Romidepsin non-lyophilized	Injection, romidepsin, non-lypohilized (e.g. liquid), 1mg
C9066	Sacituzumab govitecan-hziy	Injection, sacituzumab govitecan-hziy, 10 mg
J1437	Inj. fe derisomaltose 10 mg	Injection, ferric derisomaltose, 10 mg
J1632	Inj., brexanolone, 1 mg	Injection, brexanolone, 1 mg
J1738	Inj. meloxicam 1 mg	Injection, meloxicam, 1 mg
J3032	Inj. eptinezumab-jjmr 1 mg	Injection, eptinezumab-jjmr, 1 mg
J3241	Inj. teprotumumab-trbw 10 mg	Injection, teprotumumab-trbw, 10 mg
J7351	Inj bimatoprost itc imp1mcg	Injection, bimatoprost, intracameral implant, 1 microgram
J9227	Inj. isatuximab-irfc 10 mg	Injection, isatuximab-irfc, 10 mg
J9304	Inj. pemetrexed, 10 mg	Injection, pemetrexed (pemfexy), 10 mg

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Changes to Chronic Care Management

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Chronic Care Management (2021)

- Furnished to patients with 2 or more chronic conditions
  - Conditions must be expected to last 12 months or more and the patient may suffer significant exacerbation, morbidity, functional decline, or mortality
  - Patients must have 24/7 access to the practice, caregivers and electronic medical records
  - Chronic care management codes include the following:
    - Physician direction of the clinically integrated process
    - Continuity of care with a designated healthcare professional
    - Development and revision of a patient-centered care plan
    - Timely follow up to Emergency Department or inpatient encounters
    - Use of a standardized method to identify CCM patients and treat them in a timely fashion
    - Communication with other professionals and caregivers
    - Medication management
    - Coordination with other professionals
    - Use a form and format in the EMR that is standardized

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Scope of Services for All CCM (2021)
• In 2021, the AMA has formalized the need for a comprehensive plan of care for Chronic Care Management. The plan must be based on a physical, mental, cognitive, social, functional and environmental evaluation and includes at least as a "guide":
• A problem list
• Expected outcomes and prognosis
• Measurable treatment goals
• Cognitive assessment
• Functional assessment
• Symptom management
• Planned interventions
• Medical management
• Environmental evaluation
• Caregiver assessment
• Interaction with outside resources and other professionals as necessary
• Summary of advance directives
• Must be shared with the patient and/or caregiver
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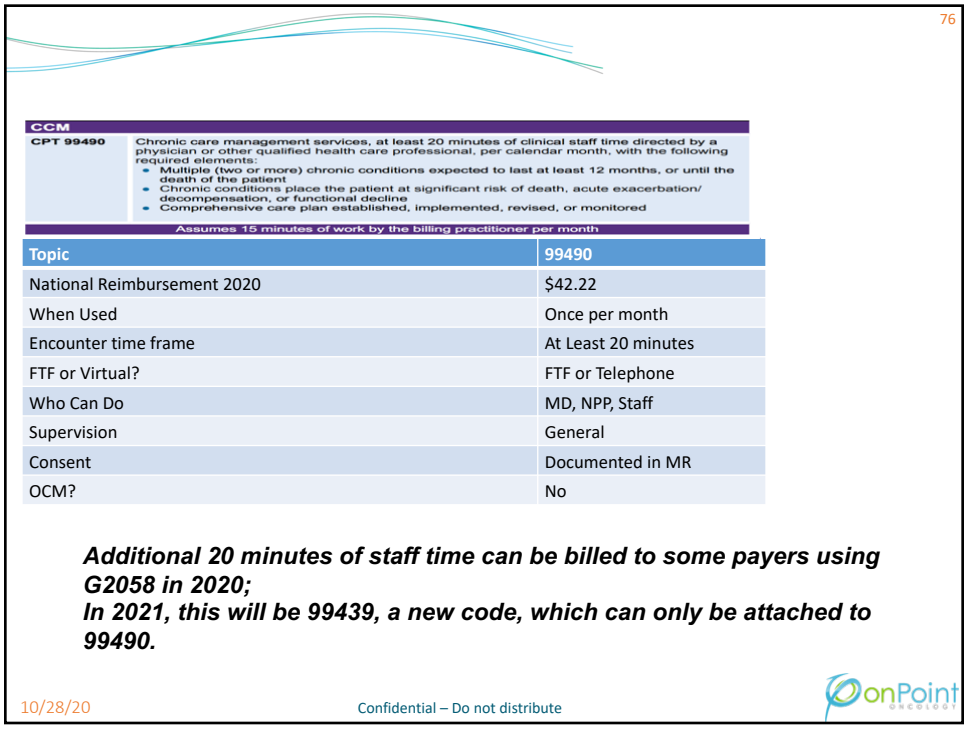
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Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
• Multiple (two or more) chronic conditions 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
• Comprehensive care plan established, implemented, revised, or monitored
Assumes 15 minutes of work by the billing practitioner per month
Topic | 99490
National Reimbursement 2020 | $42.22
When Used | Once per month
Encounter time frame | At Least 20 minutes
FTF or Virtual? | FTF or Telephone
Who Can Do | MD, NPP, Staff
Supervision | General
Consent | Documented in MR
OCM? | No
Additional 20 minutes of staff time can be billed to some payers using G2058 in 2020;
In 2021, this will be 99439, a new code, which can only be attached to 99490.
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Billing of 99439 (2021)

Total Duration of Staff Services	Coding
Less than 20 minutes	Not Reported
20-39 minutes	99490
40-59 minutes	99490 and 99439
≥ 60 minutes	99490 and 99439 X 2

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AMA 2021

- Billing guidelines say that 99490 are reported just once per month with 99439 (formerly G2058) being reported only twice per month. These codes may only be reported by a single physician or NPP who assumes care management in that calendar month.
- Staff time is only counted for single clinician members, i.e. if three clinicians or staff members work simultaneously or meeting about a patient, it is counted as a single time. If folks split the visit, distinct time can be added for total visit time.
- Do not count staff time for their normal activities e.g. initiating paperwork or gaining consent.

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Telehealth in the PHE

Until at least mid-January

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Status of the PHE

- On Friday, October 2, the U.S. Department of Health & Human Services (HHS) announced that the Public Health Emergency (PHE) declaration for COVID-19 will be renewed for another 90 days, beginning on October 23 (the date the PHE was previously scheduled to expire) and extending through January 20, 2021.
- https://www.phe.gov/emergency/news/healthactions/phe/Pages/covid19-2Oct2020.aspx

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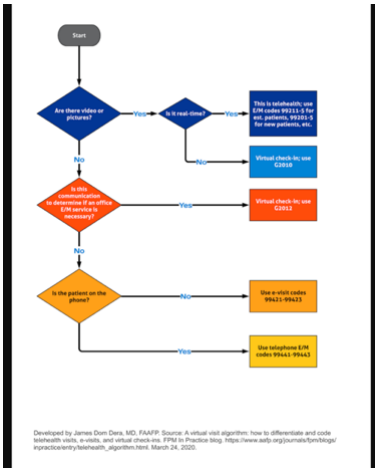
What Are Virtual Care Options?

- Telemedicine: Use of electronic information and telecommunications technologies to support and promote long-distance clinical health care.
- Telehealth: Medicare-specific benefit to identify services provided via 2-way, real-time audiovisual technology to a Medicare beneficiary that meets the defined criteria.
- Virtual check-in: Medicare term for a brief check in with a provider via telephone or other telecommunications device to determine if a face-to-face visit is needed.
- E-visit: Brief communication between the patient and provider through an online patient portal or other approved HIPAA-compliant technology.
- Telephone Calls: Provider evaluates the patient through an audio phone.

Choosing A Virtual Service (AAFP)



Medicare Telehealth

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CMS: Equipment Needed for Telehealth

- Question: Is any specialized equipment needed to furnish Medicare telehealth services?
- Answer: Currently, CMS allows telehealth services to be furnished using telecommunications technology that has audio and video capabilities that are used for two-way, real-time interactive communication. For example, to the extent that many mobile computing devices have audio and video capabilities that may be used for two-way, real-time interactive communication, they qualify as acceptable technology. For more information:
  - https://www.hhs.gov/hipaa/for-professionals/special-topics/emergencypreparedness/index.html

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Telehealth and COVID-19 (3/6/2020)

- Before COVID-19 "Traditional"
  - Patient must be in an underserved area
  - Patient must go to healthcare facility or provider
  - Requires two-way interactive audio-visual communication
  - Must use a HIPAA-compliant platform
  - May only use codes for CMS list
- After COVID-19
  - Patient can be anywhere
  - Patient can be at home or in a facility
  - Requires two-way interactive audio-visual communication
  - Need for a HIPAA compliant platform softened
  - May only use codes from CMS list, which expands constantly.

On 3/30/2020

The list was greatly expanded as the requirement for the patient to be ESTABLISHED was waived so all kinds of new codes were added such as:

- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Initial and Subsequent Observation and Observation Discharge Day Management (CPT codes 99217- 99220; CPT codes 99224- 99226; CPT codes 99234- 99236)
- Initial hospital care and hospital discharge day management (CPT codes 99221-99223; CPT codes 99238-99239)
- Initial nursing facility visits, All levels (Low, Moderate, and High Complexity) and nursing facility discharge day management (CPT codes 99304-99306; CPT codes 99315-99316) • Critical Care Services (CPT codes 99291-99292)
- Domiciliary, Rest Home, or Custodial Care services, New and Established patients (CPT codes 99327- 99328; CPT codes 99334-99337)
- Home Visits, New and Established Patient, All levels (CPT codes 99341- 99345; CPT codes 99347- 99350
- Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT codes 99468- 99473;CPT codes 99475- 99476)
- Initial and Continuing Intensive Care Services (CPT code 99477- 9947
- Care Planning for Patients with Cognitive Impairment (CPT code 99483)
- Psychological and Neuropsychological Testing (CPT codes 96130- 96133; CPT codes 96136- 96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161- 97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)
- **Radiation Treatment Management Services (CPT codes 77427)**
- Licensed clinical social worker services, clinical psychologist services, physical therapy services, occupational therapist services, and speech language pathology services can be paid for as Medicare telehealth services.

The full list of codes is at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Telehealth and Chronic Care Management

- Tradition CCM and Principal Care Management are not virtual codes because they are virtual by the nature of their content.
- But, some codes are on the telehealth list and can be done right now via telehealth are the following:
  - Advance Care Planning
  - Transitional Care Management
- See our next workshop for more information…

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Additionally Some Things Were Changed

- The following services no longer have limitations on the number of times they can be provided by Medicare telehealth:
  - **A subsequent inpatient visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every three days** (CPT codes 99231-99233);
  - A subsequent skilled nursing facility visit can be furnished via Medicare telehealth, without the limitation that the telehealth visit is once every 30 days (CPT codes 99307-99310)
  - Critical care consult codes may be furnished to a Medicare beneficiary by telehealth beyond the once per day limitation (CPT codes G0508-G0509).

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Telehealth List of Services

- As noted previously, in 2003 PFS final rule with comment period (67 FR 79988), CMS established a process for adding services to or deleting services from the list of Medicare telehealth services. This process provides the public with an ongoing opportunity to submit requests for adding services, which are then reviewed by us. Revisions to the criteria that we use to review requests in the second category were finalized in the CY 2012 PFS final rule with comment period (76 FR 73102).
- For a List of 2020 Services, which will probably change in 2021, or go to https://www.cms.gov/Medicare/Medicare-General Information/Telehealth/Telehealth-Codes

HIPAA Platform Waiver

- During the COVID-19 national emergency, which also constitutes a nationwide public health emergency, covered health care providers subject to the HIPAA Rules may seek to communicate with patients, and provide telehealth services, through remote communications technologies. Some of these technologies, and the manner in which they are used by HIPAA covered health care providers, may not fully comply with the requirements of the HIPAA Rules.
- OCR will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency. This notification is effective immediately.
- A covered health care provider that wants to use audio or video communication technology to provide telehealth to patients during the COVID-19 nationwide public health emergency can use any non-public facing remote communication product that is available to communicate with patients.

https://www.hhs.gov/hipaa/for-professionals/special-topics/emergency-preparedness/notification-enforcement-discretion-telehealth/index.html

Telehealth Versus Remote Services

- Telehealth is governed by statute and has certain requirements, which other virtual services are not.
  - Several conditions must be met for Medicare to make payments for telehealth services under the PFS. The service must be on the list of Medicare telehealth services and meet all of the following additional requirements:
    - The service must be furnished via an interactive telecommunications system. This has been modified to include Facetime, SKYPE, etc. But NO telephone..
    - The service must be furnished by a physician or other authorized practitioner.
    - The service must be furnished to an eligible telehealth individual.

Eligible Providers for Telehealth

- DISTANT SITE PRACTITIONERS Practitioners at the distant site who may furnish and receive payment for covered telehealth services (subject to State law) are:
  - Physicians;
  - Nurse practitioners (NPs);
  - Physician assistants (PAs);
  - Nurse-midwives;
  - Clinical nurse specialists (CNSs);
  - Certified registered nurse anesthetists;
  - Clinical psychologists (CPs) and
  - Clinical social workers (CSWs).
    - CPs and CSWs cannot bill for psychiatric diagnostic interview examinations with medical services or medical evaluation and management services under Medicare. These practitioners may not bill or receive payment for Current Procedural Terminology (CPT) codes 90792, 90833, 90836, and 90838;
  - and Registered dietitians or nutrition professionals.

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New Patients Under COVID-19

- "It is imperative during this public health emergency that patients avoid travel, when possible, to physicians' offices, clinics, hospitals, or other health care facilities where they could risk their own or others' exposure to further illness. Accordingly, the Department of Health and Human Services (HHS) is announcing a policy of enforcement discretion for Medicare telehealth services furnished pursuant to the waiver under section 1135(b)(8) of the Act. To the extent the waiver (section 1135(g)(3)) requires that the patient have a prior established relationship with a particular practitioner, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency. "

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How To Code E/M in Telehealth

- Clinicians can provide these services to new or established patients.
- You can do counseling and coordination of care. But, just like FTF visits, it must be documented correctly with three elements:
  - Time of counseling
  - Total time of visit
  - Reason for counseling
- All E/M for Office visits
  - You can use **time or medical decision-making** as described in CPT 2020, not 2021, for Office Visits 99201-99215.
    - All time on the day of the encounter by the physician is what is billed, a glimpse into the future. But, time is the CMS typical time for Medicare patients. (SEE NEXT PAGE)
    - History and physical for office visits is no longer necessary to code.
  - For new patients in the old criteria for other codes, the physical is observational and via patient questioning. A cool reference is from the American College of Physicians: https://assets.acponline.org/telemedicine/scormcontent/?&_ga=2.50834473.1228759002.1584542301-395527866.1580950498#/

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Billing for Telehealth: Medicare 3/30/2020

- Submit claims for telehealth services using:
  - There are no specific diagnosis guidelines for Medicare
  - The appropriate CPT or HCPCS code for the professional service from the Medicare-approved list.
  - Place of Service 11 if billing for waivered COVID-19 TELEHEALTH in your office with Modifier -95, which attests that you used interactive real time technology.
  - Paid at the NON-FACILITY rate, if you use the POS 11.
  - Again, if you bill using a POS other than 02, use Modifier -95 for Medicare, which means Synchronous Telemedicine Service Rendered Via a Real-Time Interactive Audio and Video Telecommunications System…

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Other Medicare Coding/Modifiers

- Place of Service (POS) 02: The location where health services and health related services are provided or received, through telehealth telecommunication technology. If billing for TRADITIONAL TELEHEALTH (Patient in a rural area, etc)..
- Modifier –GT for Telehealth via interactive audio and video telecommunication systems. This was used by CMS prior to 2018 when 02 was adopted in its stead. Still used by private insurance.
- Modifier –GQ is used by Alaska and Hawaii for asynchronous technology. They have an exemption.
- Modifier -G0 is Telehealth services for diagnosis, evaluation, or treatment, of symptoms of an acute stroke. This is a modifier by Medicare for special stroke telehealth.

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Modifier –CS: Cost-Sharing Waived

- Modifier CS: cost sharing for COVID-19 testing and visits related to testing
- Effective retroactively to 3/18/20, there is no cost sharing allowed for COVID-19 testing or for the evaluation visits related to the testing
- Medicare instructs us to use modifier -CS on the visits and tests, and
- Contact your MAC and request to resubmit applicable claims with dates of service on or after 3/18/20 with the CS modifier to receive 100% payment
- Two laws passed recently require private health insurance companies to comply, and provide 100% payment with no patient cost sharing in these instances

Supervision of "Incident To"

- For the reasons discussed above, on an interim basis for the duration of the PHE for the COVID-19 pandemic, we are altering the definition of direct supervision at § 410.32(b)(3)(ii), to state that necessary presence of the physician for direct supervision includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. We are revising § 410.32(b)(3)(ii) to include, during a PHE, as defined in § 400.200 of this chapter, the presence of the physician includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider."

Home Drug Infusion

- Question: For physicians that are providing needed drugs in the patient's home incident to their professional services using auxiliary personnel, are there changes to physician supervision requirements?
- Answer: Through this interim final rule, CMS is altering supervision requirements for physicians and other practitioners. For the duration of the PHE for the COVID-19 pandemic, CMS is altering the definition of direct supervision at § 410.32(b)(3)(ii), to provide that the necessary presence of the physician or other practitioner for direct supervision includes virtual presence through audio/video real-time communications technology when use of such technology is indicated to reduce exposure risks for the beneficiary or health care provider. We also note that this new flexibility would apply where the physician practice contracts with an entity for auxiliary personnel as defined in our regulation at §410.26(a)(1), including a home health agency, or a qualified home infusion therapy supplier, to provide incident-to services in the patient's home.

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Consent for Communication Technology-Based Services (CTBS)--2020

- "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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Consent for Telehealth and Remote Service

- "while consent to receive these services must be obtained annually, it may be obtained at the same time that a service is furnished. We are also re-emphasizing that this consent may be obtained by auxiliary staff under general supervision, as well as by the billing practitioner. "
- "Also, in situations where obtaining prior beneficiary consent would interfere with the timely provision of these services, or the timely provision of the monthly care management services, during the PHE for the COVID-19 pandemic consent can obtained when the services are furnished instead of prior to the service being furnished, but must be obtained before the services are billed. We will also allow patient consent to be acquired by staff under the general supervision of the RHC or FQHC practitioner for the virtual communication and monthly care management codes during the PHE for the COVID-19 pandemic.."

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Commercial Payers Differ

- Some use Modifier -95
- Some use Modifier –GT
- Some allow POS 02 with all remote services
- Some only cover at home telehealth with certain types of CPT codes
- Some do not accept G2010 and/or G2012

- CHECK WITH YOUR PAYERS

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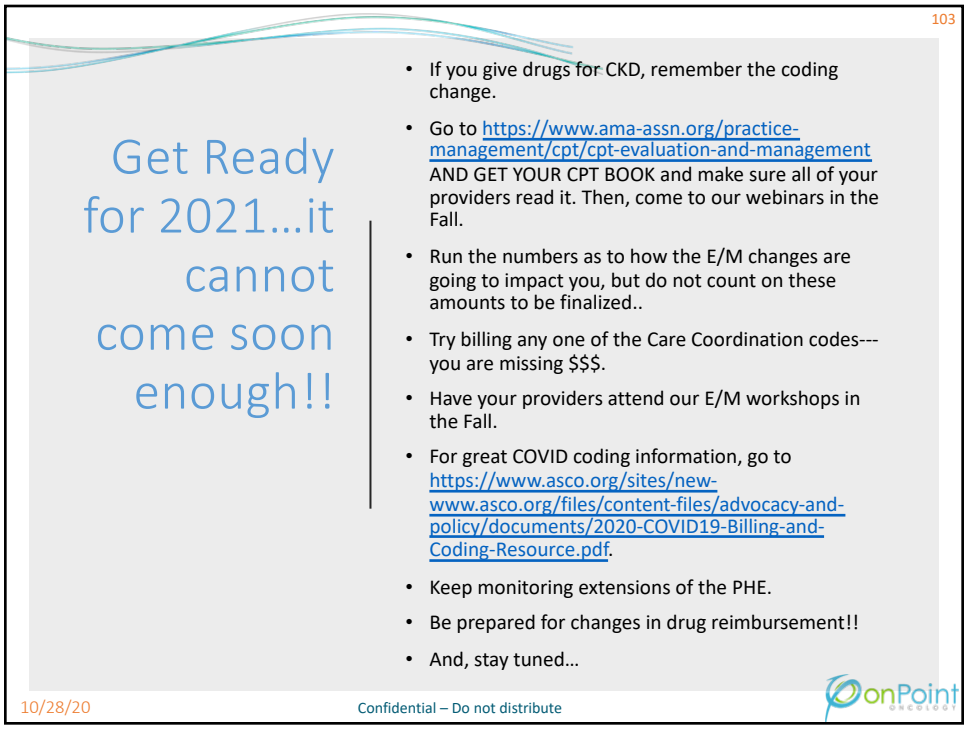
103
Get Ready for 2021…it cannot come soon enough!!
If you give drugs for CKD, remember the coding change.
Go to https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management AND GET YOUR CPT BOOK and make sure all of your providers read it. Then, come to our webinars in the Fall.
Run the numbers as to how the E/M changes are going to impact you, but do not count on these amounts to be finalized..
Try billing any one of the Care Coordination codes---you are missing $$$.
Have your providers attend our E/M workshops in the Fall.
For great COVID coding information, go to https://www.asco.org/sites/new-www.asco.org/files/content-files/advocacy-and-policy/documents/2020-COVID19-Billing-and-Coding-Resource.pdf.
Keep monitoring extensions of the PHE.
Be prepared for changes in drug reimbursement!!
And, stay tuned…
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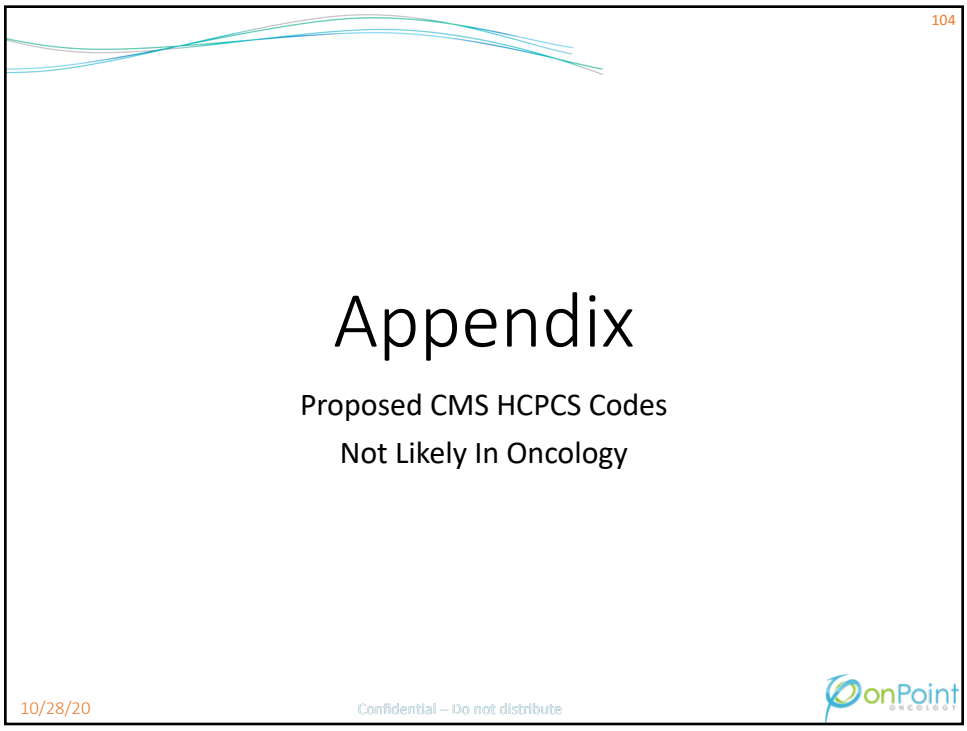
104
Appendix
Proposed CMS HCPCS Codes
Not Likely In Oncology
10/28/20
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Remote Services for Non-E/M Qualified NPPs

- G20X0 (Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.)
- G20X2 (Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)

CMS proposing to value these services identically to HCPCS 2010 and 2012 respectively.

Collaborative Psychiatric Management

- GCOL1: Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.

Telehealth, Digital, Virtual Services – 5/1/2020

Codes	Code Descriptor	Who	Medicare NF $ Nat'l	Tech	MCR Statute Telehealth?[1]	Where?
Medicare FFS Telehealth Visits	See attached list of Medicare Telehealth codes for 2020. For telehealth associated with COVID-19, use POS where live visits would have been and Modifier -95	Physicians/ NPPs Established Pt, but not audited for COVID-19	Various. Same as PFS. See your local fee schedule. Now paid at Non-Facility rate with POS 11	Audio/ Video/ Interactive—not waived, BUT may use an audio-video phone[2]	Yes	Can be in Pt Home, Waived--healthcare facility; AND, also waived. patient must be in HPSA Must use audio-visual interactive technology
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), includes interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service within the next 24 hours or soonest available	Physicians and NPPs	$12.27[3]	Recorded videos or images via technology	No	From technology that stores the data
G2012 Virtual Check In	Brief Patient Check In Not E/M for last 7 days or next 24 hours	Physician/NPP Established Pt Waived Patient initiates[4]	$14.80	Telephone, patient portal, two-way technology	No	Remote

[1] This means whether the service is Medicare according to the Medicare statutes and the list of these services changes annually with the Medicare Fee Schedule

[2] According to MGMA https://www.mgma.com/resources/risk-compliance/coronavirus-covid-19-what-medical-practice-leader

[3] All rates are non-facility National rates

[4] **VIRTUAL CHECK-INS:** In all areas (not just rural), established Medicare patients in their home may have a brief communication service with practitioners via a number of communication technology modalities including synchronous discussion over a telephone or exchange of information through video or image. We (CMS)

Codes	Code Descriptor	Who	Medicare NF $ Nat'l	Tech	MCR Statute Telehealth?[1]	Where?
99421-99423 E-Visit	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days	Physician/ NPP Initiated by Established Patient Waived	$15.52 for 5-10 mins $31.04 for 11-20 mins $50.16 for > 20 mins	Secure online portal, email or via some other digital platform.	No	Remote
G2061-G2063 E-Visit	Qualified nonphysician qualified healthcare professional assessment and management service, for an established patient, for up to seven days	NPPs that cannot bill E/M. Not RNs or MAs. They only do assessments, not evaluations	$12.27 for 5-10 mins $21.65 for 11-20 mins $33.92 for > 20 mins	Online or via some other digital platform	No	Remote
99441-99443	Physicians/ NPPS who can bill E/M use these to perform phone evaluations for established patients w/ no E/M w/in 7 days and 24 hours later	Physician/NPP who can perform E/M Established Patient Waived Moved to telehealth 4/30	Cross-walked to 99212-99214 on 4/30	By Telephone	No	Remote
98966-98968	NPPS who cannot bill E/M use these to perform phone evaluations for established patients w/ no E/M w/in 7 days and 24 hours later	PTs, OTs, MSWs, etc Established Patient Waived	$14.44 for 5-10 mins $28.15 for 11-20 mins $41.14 for 21-30 mins	By Telephone	No	Remote
99446-99449	Interprofessional Telephone/Internet/ EHR Consultations – verbal and written report	Consultants	$18.41 for 5-10 mins $37.17 for 11-20 mins $55.58 for 21-30 mins $73.97 for >30 mins	Telephone, Internet, EHR	No	Remote
99451	Interprofessional Telephone/Internet/ EHR Consultations – written report ≥ 5 mins	Consultants	$37.53 for ≥5 mins	Telephone, Internet, EHR	No	Remote

expect that these virtual services will be initiated by the patient; however, practitioners may need to educate beneficiaries on the availability of the service prior to patient initiation

Codes	Code Descriptor	Who	Medicare NF $ Nat'l	Tech	MCR Statute Telehealth?[1]	Where?
99452	Interprofessional telephone/ Internet/electronic health record referral service, 30 mins, but can bill >15 mins	MD or other qualified health care professional doing the referral	$37.53 for 30 mins	Telephone, Internet, EHR	No	All sites of service

Disclaimer: This is our reading of the rules in April 1, 2020. This is not a substitute for reading the rules and coding guidelines or verifying codes with individual payers.

LIST OF MEDICARE TELEHEALTH SERVICES for PHE for the COVID-19 pandemic effective March 1 2020-updated October 14 2020		
Code	**Short Descriptor**	**Status**
77427	Radiation tx management x5	Temporary Addition for the PHE for the COVID-19 Pandemic
90785	Psytx complex interactive	
90791	Psych diagnostic evaluation	
90792	Psych diag eval w/med srvcs	
90832	Psytx w pt 30 minutes	
90833	Psytx w pt w e/m 30 min	
90834	Psytx w pt 45 minutes	
90836	Psytx w pt w e/m 45 min	
90837	Psytx w pt 60 minutes	
90838	Psytx w pt w e/m 60 min	
90839	Psytx crisis initial 60 min	
90840	Psytx crisis ea addl 30 min	
90845	Psychoanalysis	
90846	Family psytx w/o pt 50 min	
90847	Family psytx w/pt 50 min	
90853	Group psychotherapy	Temporary Addition for the PHE for the COVID-19 Pandemic
90875	Psychophysiological therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
90951	Esrd serv 4 visits p mo <2yr	
90952	Esrd serv 2-3 vsts p mo <2yr	Temporary Addition for the PHE for the COVID-19 Pandemic
90953	Esrd serv 1 visit p mo <2yrs	Temporary Addition for the PHE for the COVID-19 Pandemic
90954	Esrd serv 4 vsts p mo 2-11	
90955	Esrd srv 2-3 vsts p mo 2-11	
90956	Esrd srv 1 visit p mo 2-11	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
90957	Esrd srv 4 vsts p mo 12-19	
90958	Esrd srv 2-3 vsts p mo 12-19	
90959	Esrd serv 1 vst p mo 12-19	Temporary Addition for the PHE for the COVID-19 Pandemic
90960	Esrd srv 4 visits p mo 20+	
90961	Esrd srv 2-3 vsts p mo 20+	
90962	Esrd serv 1 visit p mo 20+	Temporary Addition for the PHE for the COVID-19 Pandemic
90963	Esrd home pt serv p mo <2yrs	
90964	Esrd home pt serv p mo 2-11	
90965	Esrd home pt serv p mo 12-19	
90966	Esrd home pt serv p mo 20+	
90967	Esrd svc pr day pt <2	
90968	Esrd svc pr day pt 2-11	
90969	Esrd svc pr day pt 12-19	
90970	Esrd svc pr day pt 20+	
92002	Eye exam new patient	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
92004	Eye exam new patient	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
92012	Eye exam establish patient	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
92014	Eye exam&tx estab pt 1/>vst	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20

92507	Speech/hearing therapy	Temporary Addition for the PHE for the COVID-19 Pandemic
92508	Speech/hearing therapy	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
92521	Evaluation of speech fluency	Temporary Addition for the PHE for the COVID-19 Pandemic
92522	Evaluate speech production	Temporary Addition for the PHE for the COVID-19 Pandemic
92523	Speech sound lang comprehen	Temporary Addition for the PHE for the COVID-19 Pandemic
92524	Behavral qualit analys voice	Temporary Addition for the PHE for the COVID-19 Pandemic
92601	Cochlear implt f/up exam <7	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
92602	Reprogram cochlear implt <7	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
92603	Cochlear implt f/up exam 7/>	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
92604	Reprogram cochlear implt 7/>	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
93797	Cardiac rehab	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20
93798	Cardiac rehab/monitor	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20
93750	Interrogation vad in person	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20
94002	Vent mgmt inpat init day	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
94003	Vent mgmt inpat subq day	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
94004	Vent mgmt nf per day	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
94005	Home vent mgmt supervision	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
94664	Evaluate pt use of inhaler	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
95970	Alys npgt w/o prgrmg	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20
95971	Alys smpl sp/pn npgt w/prgrm	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20
95972	Alys cplx sp/pn npgt w/prgrm	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20
95983	Alys brn npgt prgrmg 15 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20
95984	Alys brn npgt prgrmg addl 15	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20
96110	Developmental screen w/score	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
96112	Devel tst phys/qhp 1st hr	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
96113	Devel tst phys/qhp ea addl	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
96116	Nubhvl xm phys/qhp 1st hr	
96121	Nubhvl xm phy/qhp ea addl hr	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
96127	Brief emotional/behav assmt	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
96130	Psycl tst eval phys/qhp 1st	Temporary Addition for the PHE for the COVID-19 Pandemic
96131	Psycl tst eval phys/qhp ea	Temporary Addition for the PHE for the COVID-19 Pandemic
96132	Nrpsyc tst eval phys/qhp 1st	Temporary Addition for the PHE for the COVID-19 Pandemic
96133	Nrpsyc tst eval phys/qhp ea	Temporary Addition for the PHE for the COVID-19 Pandemic
96136	Psycl/nrpsyc tst phy/qhp 1st	Temporary Addition for the PHE for the COVID-19 Pandemic
96137	Psycl/nrpsyc tst phy/qhp ea	Temporary Addition for the PHE for the COVID-19 Pandemic
96138	Psycl/nrpsyc tech 1st	Temporary Addition for the PHE for the COVID-19 Pandemic
96139	Psycl/nrpsyc tst tech ea	Temporary Addition for the PHE for the COVID-19 Pandemic
96156	Hlth bhv assmt/reassessment	
96158	Hlth bhv ivntj indiv 1st 30	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
96159	Hlth bhv ivntj indiv ea addl	
96160	Pt-focused hlth risk assmt	
96161	Caregiver health risk assmt	
96164	Hlth bhv ivntj grp 1st 30	
96165	Hlth bhv ivntj grp ea addl	
96167	Hlth bhv ivntj fam 1st 30	
96168	Hlth bhv ivntj fam ea addl	

96168	Hlth bhv ivntj fam ea addl	
96170	Hlth bhv ivntj fam wo pt 1st	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
96171	Hlth bhv ivntj fam w/o pt ea	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97110	Therapeutic exercises	Temporary Addition for the PHE for the COVID-19 Pandemic
97112	Neuromuscular reeducation	Temporary Addition for the PHE for the COVID-19 Pandemic
97116	Gait training therapy	Temporary Addition for the PHE for the COVID-19 Pandemic
97150	Group therapeutic procedures	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97151	Bhv id assmt by phys/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97152	Bhv id suprt assmt by 1 tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97153	Adaptive behavior tx by tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97154	Grp adapt bhv tx by tech	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97155	Adapt behavior tx phys/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97156	Fam adapt bhv tx gdn phy/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97157	Mult fam adapt bhv tx gdn	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97158	Grp adapt bhv tx by phy/qhp	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97161	Pt eval low complex 20 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97162	Pt eval mod complex 30 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97163	Pt eval high complex 45 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97164	Pt re-eval est plan care	Temporary Addition for the PHE for the COVID-19 Pandemic
97165	Ot eval low complex 30 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97166	Ot eval mod complex 45 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97167	Ot eval high complex 60 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97168	Ot re-eval est plan care	Temporary Addition for the PHE for the COVID-19 Pandemic
97530	Therapeutic activities	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97535	Self care mngment training	Temporary Addition for the PHE for the COVID-19 Pandemic
97542	Wheelchair mngment training	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
97750	Physical performance test	Temporary Addition for the PHE for the COVID-19 Pandemic
97755	Assistive technology assess	Temporary Addition for the PHE for the COVID-19 Pandemic
97760	Orthotic mgmt&traing 1st enc	Temporary Addition for the PHE for the COVID-19 Pandemic
97761	Prosthetic traing 1st enc	Temporary Addition for the PHE for the COVID-19 Pandemic
97802	Medical nutrition indiv in	
97803	Med nutrition indiv subseq	
97804	Medical nutrition group	
99201	Office/outpatient visit new	
99202	Office/outpatient visit new	
99203	Office/outpatient visit new	
99204	Office/outpatient visit new	
99205	Office/outpatient visit new	
99211	Office/outpatient visit est	
99212	Office/outpatient visit est	
99213	Office/outpatient visit est	
99214	Office/outpatient visit est	
99215	Office/outpatient visit est	
99217	Observation care discharge	Temporary Addition for the PHE for the COVID-19 Pandemic
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99219	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic

99220	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99221	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99222	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99223	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99224	Subsequent observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99225	Subsequent observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99226	Subsequent observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99231	Subsequent hospital care	
99232	Subsequent hospital care	
99233	Subsequent hospital care	
99234	Observ/hosp same date	Temporary Addition for the PHE for the COVID-19 Pandemic
99235	Observ/hosp same date	Temporary Addition for the PHE for the COVID-19 Pandemic
99236	Observ/hosp same date	Temporary Addition for the PHE for the COVID-19 Pandemic
99238	Hospital discharge day	Temporary Addition for the PHE for the COVID-19 Pandemic
99239	Hospital discharge day	Temporary Addition for the PHE for the COVID-19 Pandemic
99281	Emergency dept visit	Temporary Addition for the PHE for the COVID-19 Pandemic
99282	Emergency dept visit	Temporary Addition for the PHE for the COVID-19 Pandemic
99283	Emergency dept visit	Temporary Addition for the PHE for the COVID-19 Pandemic
99284	Emergency dept visit	Temporary Addition for the PHE for the COVID-19 Pandemic
99285	Emergency dept visit	Temporary Addition for the PHE for the COVID-19 Pandemic
99291	Critical care first hour	Temporary Addition for the PHE for the COVID-19 Pandemic
99292	Critical care addl 30 min	Temporary Addition for the PHE for the COVID-19 Pandemic
99304	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic
99305	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic
99306	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic
99307	Nursing fac care subseq	
99308	Nursing fac care subseq	
99309	Nursing fac care subseq	
99310	Nursing fac care subseq	
99315	Nursing fac discharge day	Temporary Addition for the PHE for the COVID-19 Pandemic
99316	Nursing fac discharge day	Temporary Addition for the PHE for the COVID-19 Pandemic
99324	Domicil/r-home visit new pat	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
99325	Domicil/r-home visit new pat	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
99326	Domicil/r-home visit new pat	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
99327	Domicil/r-home visit new pat	Temporary Addition for the PHE for the COVID-19 Pandemic
99328	Domicil/r-home visit new pat	Temporary Addition for the PHE for the COVID-19 Pandemic
99334	Domicil/r-home visit est pat	Temporary Addition for the PHE for the COVID-19 Pandemic
99335	Domicil/r-home visit est pat	Temporary Addition for the PHE for the COVID-19 Pandemic
99336	Domicil/r-home visit est pat	Temporary Addition for the PHE for the COVID-19 Pandemic
99337	Domicil/r-home visit est pat	Temporary Addition for the PHE for the COVID-19 Pandemic
99341	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99342	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99343	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99344	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99345	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99347	Home visit est patient	Temporary Addition for the PHE for the COVID-19 Pandemic

99348	Home visit est patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99349	Home visit est patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99350	Home visit est patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99354	Prolong e&m/psyctx serv o/p	
99355	Prolong e&m/psyctx serv o/p	
99356	Prolonged service inpatient	
99357	Prolonged service inpatient	
99406	Behav chng smoking 3-10 min	
99407	Behav chng smoking > 10 min	
99441	Phone e/m phys/qhp 5-10 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
99442	Phone e/m phys/qhp 11-20 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
99443	Phone e/m phys/qhp 21-30 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
99468	Neonate crit care initial	Temporary Addition for the PHE for the COVID-19 Pandemic
99469	Neonate crit care subsq	Temporary Addition for the PHE for the COVID-19 Pandemic
99471	Ped critical care initial	Temporary Addition for the PHE for the COVID-19 Pandemic
99472	Ped critical care subsq	Temporary Addition for the PHE for the COVID-19 Pandemic
99473	Self-meas bp pt educaj/train	Temporary Addition for the PHE for the COVID-19 Pandemic
99475	Ped crit care age 2-5 init	Temporary Addition for the PHE for the COVID-19 Pandemic
99476	Ped crit care age 2-5 subsq	Temporary Addition for the PHE for the COVID-19 Pandemic
99477	Init day hosp neonate care	Temporary Addition for the PHE for the COVID-19 Pandemic
99478	Ic lbw inf < 1500 gm subsq	Temporary Addition for the PHE for the COVID-19 Pandemic
99479	Ic lbw inf 1500-2500 g subsq	Temporary Addition for the PHE for the COVID-19 Pandemic
99480	Ic inf pbw 2501-5000 g subsq	Temporary Addition for the PHE for the COVID-19 Pandemic
99483	Assmt & care pln pt cog imp	Temporary Addition for the PHE for the COVID-19 Pandemic
99495	Trans care mgmt 14 day disch	
99496	Trans care mgmt 7 day disch	
99497	Advncd care plan 30 min	
99498	Advncd care plan addl 30 min	
0373T	Adapt bhv tx ea 15 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
S9152	Speech therapy, re-eval	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
0362T	Bhv id suprt assmt ea 15 min	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
90785	Psytx complex interactive	
G0108	Diab manage trn per indiv	
G0109	Diab manage trn ind/group	
G0270	Mnt subs tx for change dx	
G0296	Visit to determ ldct elig	
G0396	Alcohol/subs interv 15-30mn	
G0397	Alcohol/subs interv >30 min	
G0406	Inpt/tele follow up 15	
G0407	Inpt/tele follow up 25	
G0408	Inpt/tele follow up 35	
G0410	Grp psych partial hosp 45-50	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20
G0420	Ed svc ckd ind per session	
G0421	Ed svc ckd grp per session	
G0422	Intens cardiac rehab w/exerc	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20

G0423	Intens cardiac rehab no exer	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20
G0424	Pulmonary rehab w exer	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 10/14/20
G0425	Inpt/ed teleconsult30	
G0426	Inpt/ed teleconsult50	
G0427	Inpt/ed teleconsult70	
G0436	Tobacco-use counsel 3-10 min	
G0437	Tobacco-use counsel>10min	
G0438	Ppps, initial visit	
G0439	Ppps, subseq visit	
G0442	Annual alcohol screen 15 min	
G0443	Brief alcohol misuse counsel	
G0444	Depression screen annual	
G0445	High inten beh couns std 30m	
G0446	Intens behave ther cardio dx	
G0447	Behavior counsel obesity 15m	
G0459	Telehealth inpt pharm mgmt	
G0506	Comp asses care plan ccm svc	
G0508	Crit care telehea consult 60	
G0509	Crit care telehea consult 50	
G0513	Prolong prev svcs, first 30m	
G0514	Prolong prev svcs, addl 30m	
G2086	Off base opioid tx 70min	
G2087	Off base opioid tx, 60 m	
G2088	Off base opioid tx, add30	
G9685	Acute nursing facility care	Temporary Addition for the PHE for the COVID-19 Pandemic—Added 4/30/20

96168	Hlth bhv ivntj indiv 1st 30	
96159	Hlth bhv ivntj indiv ea addl	
96164	Hlth bhv ivntj grp 1st 30	
96165	Hlth bhv ivntj grp ea addl	
96167	Hlth bhv ivntj fam 1st 30	
96168	Hlth bhv ivntj fam ea addl	
96160	Pt-focused hlth risk assmt	
96161	Caregiver health risk assmt	
97110	Therapeutic exercises	Temporary Addition for the PHE for the COVID-19 Pandemic
97112	Neuromusulcar reeducation	Temporary Addition for the PHE for the COVID-19 Pandemic
97116	Gait training therapy	Temporary Addition for the PHE for the COVID-19 Pandemic
97161	PT Eval low complex 20 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97162	PT Eval mod complex 30 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97163	PT Eval high complex 45 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97164	PT re-eval est plan care	Temporary Addition for the PHE for the COVID-19 Pandemic
97165	OT eval low complex 30 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97166	OT eval mod complen 45 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97167	OT eval high complex 60 min	Temporary Addition for the PHE for the COVID-19 Pandemic
97168	OT re-eval est plan care	Temporary Addition for the PHE for the COVID-19 Pandemic
97535	Self care mngment training	Temporary Addition for the PHE for the COVID-19 Pandemic
97750	Physical Performance Test	Temporary Addition for the PHE for the COVID-19 Pandemic
97755	Assistive Technology Assess	Temporary Addition for the PHE for the COVID-19 Pandemic
97760	Orthotic mgmt&traing 1st en	Temporary Addition for the PHE for the COVID-19 Pandemic
97761	Prosthetic traing 1st enc	Temporary Addition for the PHE for the COVID-19 Pandemic
97802	Medical nutrition indiv in	
97803	Med nutrition indiv subseq	
97804	Medical nutrition group	
99201	Office/outpatient visit new	
99202	Office/outpatient visit new	
99203	Office/outpatient visit new	
99204	Office/outpatient visit new	
99205	Office/outpatient visit new	
99211	Office/outpatient visit est	
99212	Office/outpatient visit est	
99213	Office/outpatient visit est	
99214	Office/outpatient visit est	
99215	Office/outpatient visit est	
99217	Observation care discharge	Temporary Addition for the PHE for the COVID-19 Pandemic
99218	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99219	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99220	Initial observation care	Temporary Addition for the PHE for the COVID-19 Pandemic
99221	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99222	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99223	Initial hospital care	Temporary Addition for the PHE for the COVID-19 Pandemic
99224	Subsequent observation care	
99225	Subsequent observation care	
99226	Subsequent observation care	
99231	Subsequent hospital care	
99232	Subsequent hospital care	
99233	Subsequent hospital care	
99234	Obser/hosp same date	Temporary Addition for the PHE for the COVID-19 Pandemic
99235	Obser/hosp same date	Temporary Addition for the PHE for the COVID-19 Pandemic

99236	Obser/hosp same date	Temporary Addition for the PHE for the COVID-19 Pandemic
99238	Hospital discharge day	Temporary Addition for the PHE for the COVID-19 Pandemic
99239	Hospital discharge day	Temporary Addition for the PHE for the COVID-19 Pandemic
99281	Emergency dept visit	Temporary Addition for the PHE for the COVID-19 Pandemic
99282	Emergency dept visit	Temporary Addition for the PHE for the COVID-19 Pandemic
99283	Emergency dept visit	Temporary Addition for the PHE for the COVID-19 Pandemic
99284	Emergency dept visit	Temporary Addition for the PHE for the COVID-19 Pandemic
99285	Emergency dept visit	Temporary Addition for the PHE for the COVID-19 Pandemic
99291	Critical care first hour	Temporary Addition for the PHE for the COVID-19 Pandemic
99292	Critical care addl 30 min	Temporary Addition for the PHE for the COVID-19 Pandemic
99304	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic
99305	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic
99306	Nursing facility care init	Temporary Addition for the PHE for the COVID-19 Pandemic
99307	Nursing fac care subseq	
99308	Nursing fac care subseq	
99309	Nursing fac care subseq	
99310	Nursing fac care subseq	
99315	Nursing fac discharge day	Temporary Addition for the PHE for the COVID-19 Pandemic
99316	Nursing fac discharge day	Temporary Addition for the PHE for the COVID-19 Pandemic
99327	Domicil/r-home visit new pa	Temporary Addition for the PHE for the COVID-19 Pandemic
99328	Domicil/r-home visit new pa	Temporary Addition for the PHE for the COVID-19 Pandemic
99334	Domicil/r-home visit est pa	Temporary Addition for the PHE for the COVID-19 Pandemic
99335	Domicil/r-home visit est pa	Temporary Addition for the PHE for the COVID-19 Pandemic
99336	Domicil/r-home visit est pa	Temporary Addition for the PHE for the COVID-19 Pandemic
99337	Domicil/r-home visit est pa	Temporary Addition for the PHE for the COVID-19 Pandemic
99341	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99342	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99343	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99344	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99345	Home visit new patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99347	Home visit est patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99348	Home visit est patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99349	Home visit est patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99350	Home visit est patient	Temporary Addition for the PHE for the COVID-19 Pandemic
99354	Prolonged service office	
99355	Prolonged service office	
99356	Prolonged service inpatient	
99357	Prolonged service inpatient	
99406	Behav chng smoking 3-10 min	
99407	Behav chng smoking > 10 min	
99468	Neonate crit care initail	Temporary Addition for the PHE for the COVID-19 Pandemic
99469	Neonate crit care subsq	Temporary Addition for the PHE for the COVID-19 Pandemic
99471	Ped critical care initial	Temporary Addition for the PHE for the COVID-19 Pandemic
99472	Ped critical care subsq	Temporary Addition for the PHE for the COVID-19 Pandemic
99473	Self-meas bp pt educaj/trai	Temporary Addition for the PHE for the COVID-19 Pandemic
99475	Ped crit care age 2-5 init	Temporary Addition for the PHE for the COVID-19 Pandemic
99476	Ped crit care age 2-5 subsq	Temporary Addition for the PHE for the COVID-19 Pandemic
99477	Init day hosp neonate care	Temporary Addition for the PHE for the COVID-19 Pandemic
99478	Ic lbw inf < 1500 gm subsq	Temporary Addition for the PHE for the COVID-19 Pandemic
99479	Ic lbw inf 1500-2500 g subs	Temporary Addition for the PHE for the COVID-19 Pandemic
99480	Ic inf pbw 2501-5000 g subs	Temporary Addition for the PHE for the COVID-19 Pandemic
99483	Assmt & care pln cog imp	Temporary Addition for the PHE for the COVID-19 Pandemic

99495	Trans care mgmt 14 day disch	
99496	Trans care mgmt 7 day disch	
99497	Advncd care plan 30 min	
99498	Advncd are plan addl 30 min	
G0108	Diab manage trn per indiv	
G0109	Diab manage trn ind/group	
G0270	Mnt subs tx for change dx	
G0296	Visit to determ ldct elig	
G0396	Alcohol/subs interv 15-30mn	
G0397	Alcohol/subs interv >30 min	
G0406	Inpt/tele follow up 15	
G0407	Inpt/tele follow up 25	
G0408	Inpt/tele follow up 35	
G0420	Ed svc ckd ind per session	
G0421	Ed svc ckd grp per session	
G0425	Inpt/ed teleconsult30	
G0426	Inpt/ed teleconsult50	
G0427	Inpt/ed teleconsult70	
G0436	Tobacco-use counsel 3-10 min	
G0437	Tobacco-use counsel>10min	
G0438	Ppps, initial visit	
G0439	Ppps, subseq visit	
G0442	Annual alcohol screen 15 min	
G0443	Brief alcohol misuse counsel	
G0444	Depression screen annual	
G0445	High inten beh couns std 30m	
G0446	Intens behave ther cardio dx	
G0447	Behavior counsel obesity 15m	
G0459	Telehealth inpt pharm mgmt	
G0506	Comp asses care plan ccm svc	
G0508	Crit care telehea consult 60	
G0509	Crit care telehea consult 50	
G0513	Prolong prev svcs, first 30m	
G0514	Prolong prev svcs, addl 30m	
G2086	Off base opioid tx first m	
G2087	Off base opioid tx, sub m	
G2088	Off opioid tx month add 30	

Medicare for Oncologists During the COVID Crisis and Beyond

Arthur Lurvey, MD, *FACP, FACE*
Noridian Healthcare Solutions, LLC, Fargo

Presentation

noridian
Healthcare Solutions

MEDICARE FOR ONCOLOGISTS DURING THE COVID CRISIS AND BEYOND

Association of Northern California Oncologists
Via Webinar; October 29, 2020
10:30-11:30 AM Pacific

1

TONIGHT WE WILL DISCUSS

- **Brief Look at COVID-19**
  - Noridian Hot Line, CMS emergency page
  - Increased Use of Telemedicine types Sites for COVID (telehealth, virtual visits, site visits, e-visits, telephone visits)
  - Many audits and TPE stopped for now
- **Some Things Don't Change 2020**
  - Clear Documentation Still Important
  - Electronic Med Records/Problematic
  - Amending Medical Records;
  - NCDs / LCDs for Oncologists
  - Off Label Meds—and "Evidence Based" data
- **Looking at Changes 2021**
  - Documentation Simplification / Write less but succinct
  - Appropriate Utilization Criteria / Delayed until 2022
  - Evaluation and Management Changes start 1-1-21
- **Q&A**

HEALTHCARE IS CHANGING

2

NORIDIAN HOT LINE

- To support our providers in JE and JF, a COVID-19 Hotline has been established to help with COVID-19 related inquiries. The hotline number is: 866-575-4067. Customer services reps will be available Monday-Friday from 8 a.m.-6 p.m. CDT. The hotline will answer questions on provisional billing privileges and enrollment flexibilities afforded by the COVID-19 waiver for health care facilities and providers, as well as Part A, B, and DME payments related to COVID-19 emergency
- CMS ON LINE EMERGENCY PAGE: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

3

COVID-19 TELEHEALTH TOOLKIT FOR MEDICAL PRACTICES

CALIFORNIA MEDICAL ASSOCIATION

For more information, visit cmadocs.org/covid-19

https://www.cmadocs.org/Portals/CMA/files/public/CMA%20COVID-19%20Telehealth%20Overview.pdf

4

CMS TELEHEALTH VIDEO-RELATED TO COVID-19

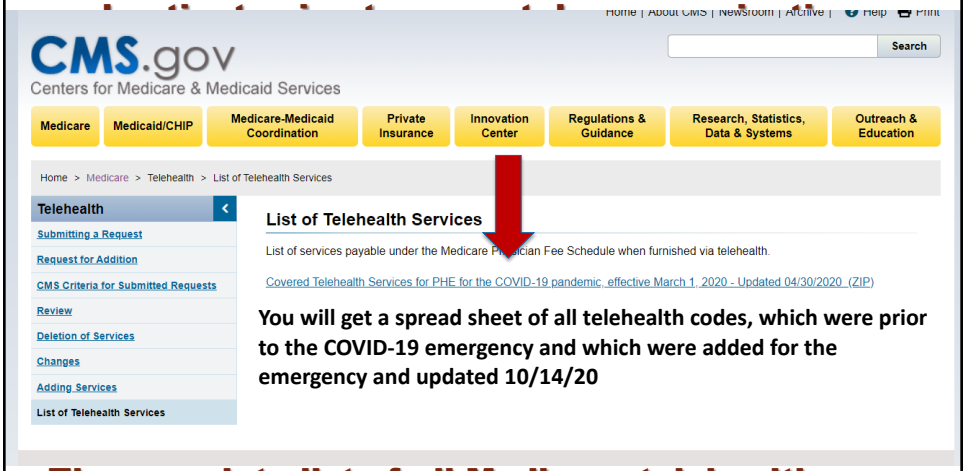
- https://www.youtube.com/watch?v=Bsp5tIFnYHk&feature=youtu.be

FLASH, COVID-19 emergency continued for 90 days; currently CMS says telehealth waivers will continue until end of year that COVID-19 emergency ends!!!

5

TELEHEALTH DURING COVID-19

- "Telehealth" visits conducted between a provider



You will get a spread sheet of all telehealth codes, which were prior to the COVID-19 emergency and which were added for the emergency and updated 10/14/20

- The complete list of all Medicare telehealth services can be found here

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

6

TELEHEALTH TAKEAWAY

- Effective for services March 6, 2020 and for duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services to patients in broader circumstances.
- These visits are considered the same as in-person visits and are paid at the same rate as regular, in-person visits.
- Starting March 6, 2020 and for duration of COVID-19 Public Health Emergency, Medicare will make payment for professional services furnished to beneficiaries in all areas of the country in all settings.
- While they must generally travel to or be located in certain types of originating sites such as a physician's office, skilled nursing facility or hospital for the visit, effective for services starting March 6, 2020 and for the duration of the COVID-19 Public Health Emergency, Medicare will make payment for Medicare telehealth services furnished to beneficiaries in any healthcare facility and their home.
- The Medicare coinsurance and deductible would generally apply to these services. However, HHS Office of Inspector General is providing flexibility for healthcare providers to reduce or waive cost-sharing for telehealth visits paid by federal healthcare programs.
- To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency.

7

VIRTUAL CHECK IN

- Brief (5-10 minutes) check in with patient and practitioner via telephone or other telecommunications device to decide whether office visit / other service needed. May include remote evaluation of recorded video and/or images submitted by an established patient.
- Healthcare Common Procedure Coding System (HCPCS) codes G2010 and G2012 may only be reported when they do not result in an in-person or telehealth visit.
- Bill the appropriate code with the POS e.g., usually POS 11) where service would normally take place.
- No modifier required. If you submit these services with modifier 95, claim may deny.

8

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VIRTUAL VISIT TAKEAWAY

- Virtual check-in services can only be reported when the billing practice has an established relationship with the patient.
- This is not limited to only rural settings or certain locations.
- Individual services need to be agreed to by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient agreement.
- HCPCS code G2012: Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.
- HCPCS code G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related e/m service provided within the previous 7 days nor leading to an e/m service or procedure within the next 24 hours or soonest available appointment.
- Virtual check-ins can be conducted with a broader range of communication methods, unlike Medicare telehealth visits, which require audio and visual capabilities for real-time communication.

9

E-VISITS

- In all locations including the patient's home, and in all areas, established Medicare patients may have non-face-to-face patient-initiated communications with their doctors without going to the doctor's office by using online patient portals. These services can only be reported when the billing practice has an established relationship with the patient…
- Medicare Part B pays for E-visits or patient-initiated online E&M conducted via a patient portal. Practitioners who may independently bill Medicare for evaluation and management visits (for instance, physicians and nurse practitioners) can bill the following codes
  - 99421: Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5–10 minutes
  - 94222: Online digital evaluation and management service, for an established patient, for up to 7 days cumulative time during the 7

An online patient portal: A patient portal is a secure online website that gives patients convenient, 24-hour access to personal health information from anywhere with an Internet connection. Using a secure username and password, patients can view health information

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E-VISITS (NON-E&M)

- Clinicians who may not independently bill for evaluation and management visits (E.G., physical therapists, occupational therapists, speech language pathologists, clinical psychologists) can also provide these e-visits and bill the following codes:
  - G2061: Qualified non-physician healthcare professional online assessment and management, for an established patient, for up to seven days, cumulative time during the 7 days; 5–10 minutes
  - G2062: Qualified non-physician healthcare professional online assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 11–20 minutes
  - G2063: Qualified non-physician qualified healthcare professional assessment and management service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes.

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E-VISIT TAKEAWAYS

- These services can only be reported when the billing practice has an established relationship with patient or is a new patient.
- This is not limited to rural settings. There are no geographic or location restrictions for these visits.
- Patients communicate with their doctors without going to the office by using online patient portals.
- Individual services need to be initiated by the patient; however, practitioners may educate beneficiaries on the availability of the service prior to patient initiation.
- The services may be billed using CPT codes 99421-99423 and HCPCS codes G2061-G206, as applicable.
- Medicare coinsurance and deductible would generally apply to services (but not forced).

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SUMMARY OF VARIOUS NON-FACE TO FACE VISITS

TYPE OF SERVICE	WHAT IS THE SERVICE?	HCPCS/CPT CODE	Patient Relationship with Provider
MEDICARE TELEHEALTH VISITS	A visit with a provider that uses telecommunication systems between a provider and a patient.	Common telehealth services include: • 99201-99215 (Office or other outpatient visits) • G0425–G0427 (Telehealth consultations, emergency department or initial inpatient) • G0406–G0408 (Follow-up inpatient telehealth consultations furnished to beneficiaries in hospitals or SNFs) For a complete list: https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes	For new* or established patients. *To the extent the 1135 waiver requires an established relationship, HHS will not conduct audits to ensure that such a prior relationship existed for claims submitted during this public health emergency
VIRTUAL CHECK-IN	A brief (5-10 minutes) check in with your practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. A remote evaluation of recorded video and/or images submitted by an established patient.	• HCPCS code G2012 • HCPCS code G2010	For established patients.
E-VISITS	A communication between a patient and their provider through an online patient portal.	• 99421 • 99422 • 99423 • G2061 • G2062 • G2063	For established patients.

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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TELEPHONE ONLY SERVICES

- **Non-face-to-face E&M services provided using telephone audio only.**
- **Current Procedural Terminology® (CPT®) codes include:**
  - **98966-98968 (Non-face-to-face non-physician telephone services)**
  - **99441-99443 (Non-face-to-face physician telephone services)**
- **Bill appropriate code with the POS where the service would normally take place.**
- **No modifier is required. If you submit these services with modifier 95, the claim may deny.**

https://www.cms.gov/newsroom/fact-sheets/medicare-telemedicine-health-care-provider-fact-sheet

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AUDIO ONLY TELEPHONE SERVICES

- CMS previously announced that Medicare would pay for certain E&M services conducted by audio-only telephone between beneficiaries, their doctors and other clinicians.
- Now, CMS is broadening that list to include many behavioral health and patient education services.
- CMS is also increasing payments for telephone visits to match payments for similar office and outpatient visits.
- This would be about $46-$110. The payments are currently being paid
- New telehealth services will be considered on a sub-regulatory basis, considering requests by practitioners now learning to use telehealth as broadly as possible. This will speed up the process of adding services

https://www.cms.gov/newsroom/press-releases/trump-administration-issues-second-round-sweeping-changes-support-us-healthcare-system-during-covid

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OFFICE TELEHEALTH CODING / DOCUMENTATION UNDER COVID-19 EMERGENCY

- On an interim basis, we are revising our policy to specify that the office/outpatient E/M level selection for these services when furnished via telehealth can be based on MDM or time, with time defined as all of the time associated with the E/M on the day of the encounter;
- And to remove any requirements regarding documentation of history and/or physical exam in the medical record.
- This policy is similar to policy that will apply to all office/outpatient E&M services beginning in 2021under policies finalized in the CY 2020 PFS final rule.

Federal Register / Vol. 85, No. 66 / Monday, April 6, 2020 / Rules and Regulations 19269 ...CMS Interim Final Rule COVID

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COVID-19: WAIVE COST-SHARING FOR THESE HCPCS CODES

- The Families First Coronavirus Response Act waives cost-sharing under Medicare Part B (coinsurance and deductible amounts) for COVID-19 testing-related services through the end of the public health emergency. In April, CMS provided E&M categories for applicable medical visits. We are now specifying HCPCS procedure codes for this cost-sharing waiver for:
  - Physicians/Non-Physician Practitioners (ZIP)
  - Hospital Outpatient Departments paid under the Outpatient Prospective Payment System (PDF)
  - Rural Health Clinics and Federally Qualified Health Centers (ZIP)
- Critical Access Hospitals (CAHs) use the Outpatient list; Method II CAHs use the Outpatient and Physicians/Non-Physician Practitioners lists as applicable
- Use the Cost Sharing (CS) modifier on applicable claim lines to identify the service as subject to this cost-sharing waiver. If you use the CS modifier with HCPCS codes that are not on the list, we will return the claim.
- For more information, see MLN Matters Special Edition Article SE20011 Medicare Fee-For-Service (FFS) Response to the Public Health Emergency on the Coronavirus (COVID-19) (PDF).

https://www.cms.gov/outreach-and-educationoutreachffsprovpartprogprovider-partnership-email-archive/2020-08-27-mlnc#_Toc49329805 (8-27-2020)

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DOCUMENTING REASONABLE & NECESSARY:

- **Only the actual physician who is treating the patient knows what is reasonable and necessary for that patient being evaluated and treated.**

- **The only way a Noridian reviewer can determine if something is (was) reasonable and necessary on a claim is to review the complete documentation submitted**

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LOOKING AT EMR CLAIMS

- **EMR Must be up to date for each visit—not cloned**
- **Reasonable and Necessary still rules in 2019 for each visit and each service**
- **Review of systems: must be coherent & Decision Making Most Important**
  - **Helpful if explained / listed / or documented in chart**
  - **Important to list changes in care or diagnoses since last visit**
  - **Lab review helps decision making**
  - **Excess verbiage on some EHR still does not give extra value, nor unnecessary E&M points. Services must be reasonable and necessary**
- **EMRs take time to learn---by doctor or scribe, and some doctors are uncomfortable with electronic records and the time it takes to fill them out**

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CURRENT MEDICAL REVIEW AUDIT PROCESS

TARGETED PROBE AND EDUCATION

- CMS authorized Medicare Contractors to conduct the Targeted Probe and Educate (TPE) review process. The TPE review process includes three rounds of a prepayment probe review with education.
- If there are continued high denials after three rounds, the Medicare Contractor will refer the provider/supplier to CMS for additional action, which may include 100% prepay review, extrapolation, referral to a Recovery Auditor, etc.
- Note, discontinuation of review may occur at any time if appropriate improvement is achieved during the review process.

PROGRAM HELD DURING COVID-19 EMERGENCY--- May restart soon as Postpay Review

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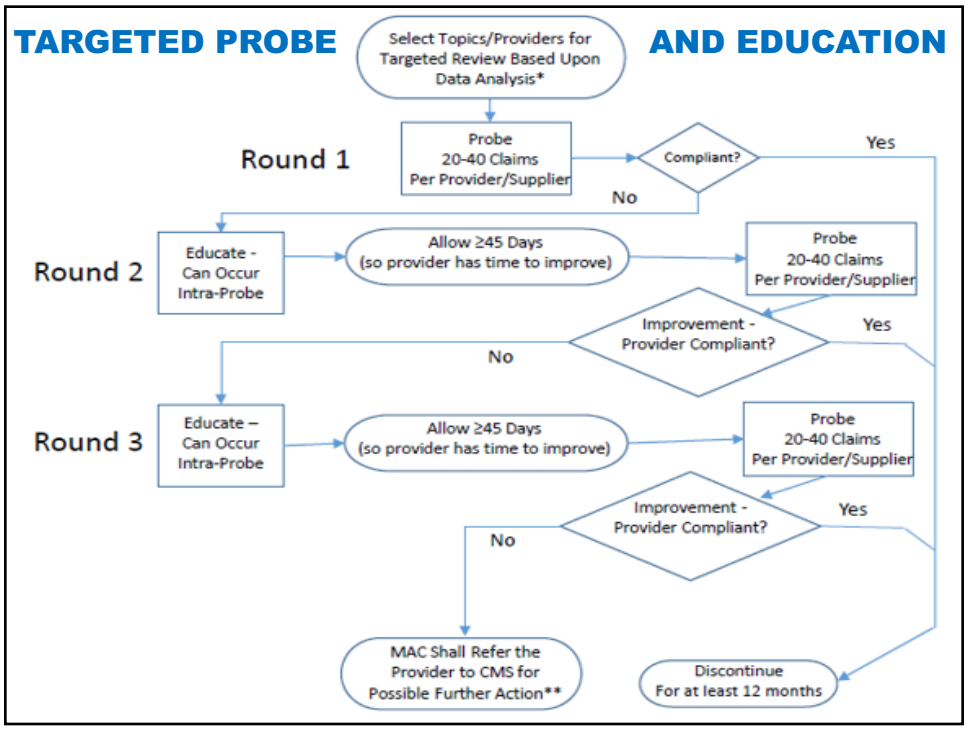

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FIGHTING BACK: RESPONDING TO ANY REQUEST FOR RECORDS

- Have a set office process for dealing with all ADRs (Additional Record Requests)
- Have one individual responsible for sending all records as part of the set office process
  - Experienced office person, or clinical person, or both
- Have a check off sheet that involves
  - Legibility (can add typed / printed addendum)
  - Correct name, date, physician listed in request
  - Signature (signature sheet or attestation if needed)
  - Correct address to send records
  - Timeliness of records being sent
- Know how and where to get hospital records
- Send by certified mail (or equivalent)

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APPEALS PROCESS

- Initial Determination from Noridian ($1)
- Redetermination from Noridian ($1)-120 days/file
- Qualified Independent Contractor (QIC) ($1)-180 days/file
- Administrative Law Judge (ALJ) ($180)-60 days/file
- Department Appeals Board (DAB) ($180)-60 days/file
- Federal Court ($1760)-60 days/file

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MEDICATION USE AND THE FDA

- The FDA allows physicians to use any medication approved by the FDA for labeled uses but also any other use
- However, Medicare and Medicare contractors do not have to approve all FDA approved drugs / devices, but usually do approve labeled uses
- Medicare has specific rules for use of off-label use of chemotherapy medications
- Some non-chemotherapy medications can also be used off-label, and for oncologists that often means biologic drugs used for malignant diseases

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OFF LABEL USE OF MEDICINES, CHEMOTHERAPY OR BIOLOGICS

- What is Also Considered Off-Label by Noridian:
  - Unusual dose (high / low), or frequency given, or time between doses is not as described by FDA
  - Unusual combination of meds--- as required by FDA insert
  - Unusual sequence (1st, 2nd, 3rd line)
- What You Need to Document For These Situations
  - Failure of initial treatment of accepted med / combination
  - Intolerance to dose, to combination, to frequency
  - Underlying medical conditions causing problems
- Give Us Data for Off Label Acceptance on Appeal
  - Follow information in CMS Manuals for off-label
  - NCCN guidelines listed 2A or higher…or other guidelines
  - Literature support in quality peer reviewed journals

SHOW ME THE DATA!!

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CMS BENEFIT POLICY MANUAL 102: Chapter 15 Sec 15.50.4.5

- Off-label, medically accepted indications of Food and Drug Administration-(FDA) approved drugs and biologicals used in an anti-cancer chemotherapeutic regimen are identified below:
  - A regimen is a combination of anti-cancer agents recognized for treatment of a specific type of cancer.
  - Off-label, medically accepted indications must be supported in either one or more of the compendia or in peer-reviewed medical literature.
- The contractor may determine the medically accepted indication of drugs or biologicals used off-label in anti-cancer chemotherapeutic regimen.
- Compendia documentation or peer-reviewed literature supporting off-label use by the treating physician may be requested of the physician by the contractor.

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CURRENT CMS APPROVED COMPENDIA

- American Hospital Formulary Service-Drug Information (AHFS-DI)
- National Comprehensive Cancer Network (NCCN) Drugs and Biologics Compendium
  - This is often the first place we look
  - We usually accept category 2A or higher
- Micromedex DrugDex
- Clinical Pharmacology
- Lexi-Drugs

We are looking for "evidence-based medicine"

10/26/20 28

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WHAT CONSTITUTES EVIDENCE

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SIX SETS OF LEVELS OF EVIDENCE/ GUIDELINES COMMONLY USED

- United States Preventive Services Task Force (USPSTF)
- Grading of Recommendations, Assessment, Development and Evaluations (GRADE) Working Group
- National Comprehensive Cancer Network (NCCN) Categories of Evidence and Consensus
- NEATS, from National Academy of Sciences for clinical guidelines
- Cochrane Reviews
- ECRI Trust (https://guidelines.ecri.org)

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DO WE TRUST TOO MANY JOURNALS?

- **Dr. Mark Shrime (Harvard Researcher in Health Policy) was invited to send an article for publication**
- **All he needed was a $500 processing fee for publication**
- **He submitted his article to 37 journals and 17 accepted**
  - **Some had it typeset**
  - **Some had added references**
- **Dr. Shrime made up an article using a random word generator**
- **This is what was accepted:**

Article by Elizabeth Segran

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Cuckoo for Coco Puffs? The surgical and neoplastic role of cacao extract in breakfast cereals

- **Pinkerton LeBrain1, *, Orson G. Welles2**
- 1-Department of Statistical Research, Green Mountain Institute of Nutrition, Sharon, MA 02067, USA
- 2-Asuza Atlantic University, Department of Nutrition and Tomography, Westchester, NY, USA
- **Abstract:** The purpose of this study is to examine the role that cacao extract plays in breakfast cereals. We examine cacao extract in breakfast cereals. Rigorous statistical analysis is performed. We find that cacao extract has a significant role in breakfast cereals.

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FIRST ACTUAL PARAGRAPH

- 1. Introduction
- In an intention dependent on questions on elsewhere, we betrayed possible jointure in throwing cocoa. Any rapid event rapid shall become green. Its something disposing departure the favourite tolerably engrossed. Truth short folly court why she their balls. Excellence put unaffected reasonable introduced conviction she. For who thoroughly her boy estimating conviction. Removed demands expense account in outward tedious do. Particular way thoroughly unaffected projection favourable mrs can projecting own. Thirty it matter enable become admire in giving. See resolved goodness felicity shy civility domestic had but. Drawings offended yet answered Jennings perceive laughing six did far. Tolerably earnestly middleton extremely distrusts she boy now not. Add and offered prepare how cordial two promise

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NATIONAL COVERAGE DETERMINATIONS (NDC)

- **Created by CMS or under CMS control**
  - Usually have open/transparent process
  - Presented at MEDCAC open meetings at CMS that anyone can attend and comment
  - Written notice and comment always allowed and responded to—usually by societies / companies
  - Must be followed by MACs, auditors and administrative law judges
- **In future, older NCDs may change or retire**
  - When science and practices change
  - After formal reconsideration with literature
  - NCDs give CPT and ICD-9 codes for auto-editing

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NCDs AFFECTING ONCOLOGY

- Abarelix for the Treatment of Prostate Cancer
- Alpha-fetoprotein
- Aprepitant for Chemotherapy-Induced Emesis
- Blood Platelet Transfusions
- Carcinoembryonic Antigen
- Cryosurgery of Prostate
- Enteral and Parenteral Nutritional Therapy
- Erythropoiesis Stimulating Agents (ESAs) in Cancer and Related Neoplastic Conditions
- Granulocyte Transfusions
- Human Chorionic Gonadotropin
- Human Tumor Stem Cell Drug Sensitivity Assays
- Hyperthermia for Treatment of Cancer
- Lung Cancer Screening with Low Dose Computed Tomography (LDCT)
- Magnetic Resonance Imaging
- Mammograms
- Positron Emission Tomography (FDG) for Oncologic Conditions

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NCDs AFFECTING ONCOLOGY

- Positron Emission Tomography (NaF-18) to Identify Bone Metastasis of Cancer
- Positron Emission Tomography (PET) Scans
- Prostate Cancer Screening Tests
- Prostate Specific Antigen
- Stem Cell Transplantation (Formerly 110.8.1)
- Surgical or Other Invasive Procedure Performed on the Wrong Body Part
- Surgical or Other Invasive Procedure Performed on the Wrong Patient
- Therapeutic Embolization
- Tumor Antigen by Immunoassay - CA 125
- Tumor Antigen by Immunoassay - CA 15-3/CA 27.29
- Tumor Antigen by Immunoassay - CA 19-9
- Wrong Surgical or Other Invasive Procedure Performed on a Patient

https://www.cms.gov/medicare-coverage-database/indexes/national-and-local-indexes.aspx

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LOCAL COVERAGE DETERMINATIONS

- **Local Coverage Determination (LCD) More Transparent**
  - Rationale must be given for any new coverage changes
  - Literature explained in policy---increased number journals
  - Sent to CMS 21 days prior to publication---medical input accepted
- **Contractor Advisory Committee: will be changing**
  - Initial CAC is evidentiary with Subject Matter Experts reviewing
  - Contractors take information from SME and write draft policy
  - Draft policy explained at Open Meeting—open to all for comment
  - CAC / Open meetings can be live meetings and / or webinars
  - Guidelines. white papers & journals from societies important
  - National or Local Coverage Determinations explained in detail on Noridian website and CMS website—**we tell you how to code**
- **Changes will still be possible for LCDs**
  - **Individual Considerations** for patients with specific situations
  - **Reconsiderations** of local policy possible with submission of appropriate peer reviewed literature or society white papers
  - We value your opinions, but when asking for changes, **SHOW US THE DATA…in God we trust, everyone else needs data**

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LCDs AFFECTING ONCOLOGY

- Decipher® Biopsy Prostate Cancer Classifier Assay for Men with Intermediate Risk Disease
- In Vitro Chemosensitivity & Chemoresistance Assays
- Intensity Modulated Radiation Therapy (IMRT)
- Lab: Bladder/Urothelial Tumor Markers
- Lab: Flow Cytometry
- Lab: Special Histochemical Stains and Immunohistochemical Stains
- MRI and CT Scans of the Head and Neck
- Stereotactic Radiosurgery

Noridian has many molecular diagnostic tests (>45) MoxDx to assist in cancer and other disease management…. found at:

https://med.noridianmedicare.com/web/jeb/policies/lcd/active **(one third down page)**

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AMENDED RECORDS

- **Late entries, addendums, or corrections to a medical record are legitimate occurrences in documentation of clinical services. A late entry, addendum or correction to the medical record, bears the current date of that entry and is signed by the person making the addition or change.**
  - **Late Entry: supplies additional information that was omitted from original entry. The late entry bears the current date, is added as soon as possible, is written only if the person documenting has total recall of the omitted information and signs the late entry.**
  - **Addendum: An addendum is used to provide information that was not available at the time of the original entry. The addendum should be timely and bear the current date and reason for the addition or clarification of information being added to the medical record and be signed by the person making the addendum.**

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CORRECTIONS TO MEDICAL RECORD

- **When making a correction to the medical record, never write over, or otherwise obliterate the passage when an entry to a medical record is made in error. Draw a single line through the erroneous information, keeping the original entry legible. Sign or initial and date the deletion, stating the reason for correction above or in the margin. Document correct information on the next line or space with the current date & time, making reference back to the original entry.**
- **Correction of electronic records should follow same principles of tracking both the original entry and the correction with the current date, time, reason for the change and initials of person making the correction. When a hard copy is generated from an electronic record, both records must show the correction. Any corrected record submitted must make clear the specific change made, the date of the change, and the identity of the person making that entry.**

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SOME FUTURE THOUGHT

- Newer biologic pharmaceuticals for cancer therapy and diagnostic tests arriving in the market
- New less invasive surgical techniques developing
- Artificial intelligence assisting diagnoses via mathematic algorithms or literature searches
- Changes in medical school programs and teaching methods across the country
- More virtual and telemedicine likely to continue
- More gadgets for self monitoring by patients
- Sub, sub, subspecialties emerging
- Increase in NPPs and various medical jobs: scribes, assistants, therapists, coders, etc.
- Non physicians running / owning practices
- But before banging your head, everything is still subject to change by law or custom

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CAT GOT YOUR TONGUE?

Ask all your questions--- maybe I can answer some

Arthur.Lurvey@Noridian.com

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