CMS Updates

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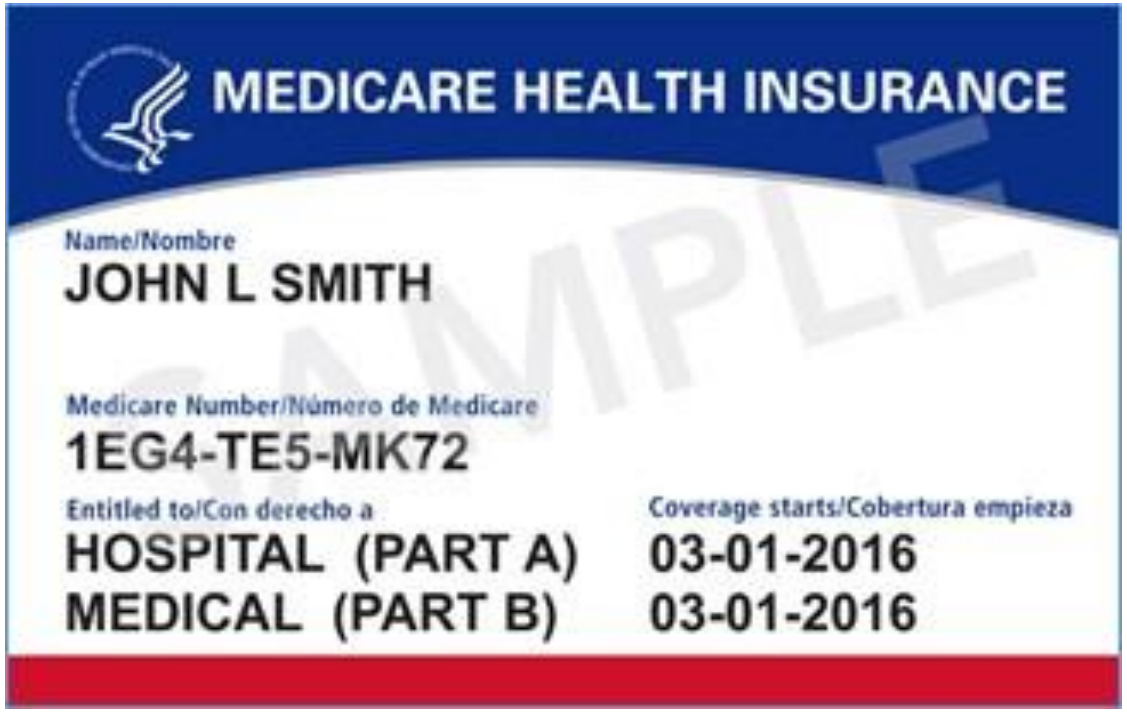
Renee Richard
Health Insurance Specialist

Introduction

- New Medicare Card
- Patients Over Paperwork
- Medical Record Documentation Supports Patient Care
- Levels of E/M Visits and Payment
- Choosing Appropriate Code and Providing Supporting Documentation
- Streamlining E/M Payment to Reduce Clinician Burden
- Documentation Changes for Office/Outpatient Visits Starting in 2019
- Documentation, Coding and Payment Changes for Office/Outpatient Visits Starting in 2021
- Advancing Virtual Care
- Quality Payment Program Update

New Medicare Card



New Medicare Card

- The same number of characters as the current HICN (11), but will be visibly distinguishable from the HICN
- Contain uppercase alphabetic and numeric characters throughout the 11-digit identifier
- Occupy the same field as the HICN on transactions
- Be unique to each beneficiary (e.g., husband and wife will have their own MBI)
- Be easy to read and limit the possibility of letters being interpreted as numbers (e.g., alphabetic characters are upper case only and **will exclude S, L, O, I, B, Z**)
- Not contain any embedded intelligence or special characters
- Not contain inappropriate combinations of numbers or strings that may be offensive

New Medicare Card Mailing

New Medicare Card Mailing Waves

Wave	States Included	Cards Mailing
Newly Eligible People with Medicare	All - Nationwide	April 2018 - ongoing
1	Delaware, District of Columbia, Maryland, Pennsylvania, Virginia, West Virginia	Beginning May 2018 **COMPLETE**
2	Alaska, American Samoa, California, Guam, Hawaii, Northern Mariana Islands, Oregon	Beginning May 2018 **COMPLETE**
3	Arkansas, Illinois, Indiana, Iowa, Kansas, Minnesota, Nebraska, North Dakota, Oklahoma, South Dakota, Wisconsin	Beginning June 2018 **COMPLETE**
4	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Rhode Island, Vermont	Beginning July 2018 **COMPLETE**
5	Alabama, Florida, Georgia, North Carolina, South Carolina	Beginning August 2018 **COMPLETE**
6	Arizona, Colorado, Idaho, Montana, Nevada, New Mexico, Texas, Utah, Washington, Wyoming	Beginning September 2018 **COMPLETE**
7	Kentucky, Louisiana, Michigan, Mississippi, Missouri, Ohio, Puerto Rico, Tennessee, Virgin Islands	Beginning October 2018

Using the New Medicare Number during Transition

- The transition period will run from **April 2018 through December 31, 2019**
- CMS will accept, use for processing, and return to stakeholders either the MBI or HICN, whichever is submitted on the claim, **during the transition period**.
- All stakeholders who submit or receive transactions containing the HICN should now be ready to submit or exchange the MBI.
- CMS will actively monitor use of HICNs and MBIs during the transition period to ensure that everyone is ready to use MBIs only by January 1, 2020

Using the New Medicare Number

- When a provider checks a beneficiary's eligibility, the CMS HIPAA Eligibility Transaction System (HETS) will return a message on the response indicating that CMS mailed that particular beneficiary's new Medicare card

- Effective October 2018 through the end of the transition period, when a **valid and active** HICN is submitted on Medicare fee-for-service claims **both the HICN and the MBI** will be returned on the remittance advice

- During the transition period, we'll process all claims with either the HICN or MBI, even when both are in the same batch

Using the New Medicare Number

- Providers/Suppliers can look up the MBI on MAC portals
- For additional information please go to the provider tab in www.CMS.gov/newcard (you can reference the portal instructions sent to all providers last September)
- Providers/Suppliers will need the following beneficiary information to look-up MBIs:
  Patient SSN
  Patient Last Name
  Patient First Name
  Patient Date of birth
  Provider/Supplier NPI

Remittance Advice

- Effective October 1, 2018, the following reports were updated to provide the new Medicare numbers when you submit a claim with a valid and active HICN

- **PC Print (Medicare Part A Providers & Facilities**
- **Medicare Remit Easy Print (MREP):**
- **Standard Paper Remits (SPRs):**

Calendar Year (CY) 2019 Medicare Physician Fee Schedule (PFS) Final Rule

Documentation and Payment for Evaluation and Management (E/M) Visits, Advancing Virtual Care, and Quality Payment Program

Patients Over Paperwork

Patients Over Paperwork

- The **Patients Over Paperwork** initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients' ability to make decisions about their own care.
- Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
- This Administration has listened and is taking action.
- The Physician Fee Schedule final rule addresses those problems by streamlining documentation requirements to focus on patient care and modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.

Patients over Paperwork: Customer Work Groups

- We have established customer-centered workgroups focusing first on clinicians, beneficiaries, nursing homes, and hospitals.

- The job of these workgroups is to learn from and understand the customer experience, internalize it, and remember these perspectives as we do this work.

- Over time, we'll establish similar workgroups across the health care spectrum.

Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is necessary for physicians and others to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.
- Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.

Evaluation and Management Services

Levels of E/M Visits and PFS Payment

- Physicians and other practitioners paid under the PFS bill for office/outpatient E/M visits using a set of CPT codes that distinguish visits based on level of complexity, site of service, and whether the patient is new or established.
- The three key components when selecting the appropriate code to bill are **history**, **examination**, and **medical decision making (MDM)**. For visits that consist predominantly of counseling and/or coordination of care, time (in conjunction with MDM) can be used as the key or controlling factor determining visit level.
- There are currently five levels of E/M office/outpatient visits (reported using CPT codes 99201-99215). Payment increases with each level.

Choosing the Appropriate Code and Providing Supporting Documentation

- For coding and billing the PFS, practitioners may use either the 1995 or 1997 E/M documentation guidelines. These are very similar to a parallel set of guidelines present in the CPT codebook.
- These guidelines specify medical record information within each of the three components that serves as support for billing a given visit level.

Why Change?

- Stakeholders have said that the E/M documentation guidelines, and the code set itself are clinically outdated and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care. Furthermore, the guidelines may not be reflective of changes in technology, or in particular, the way that electronic medical records have changed documentation and the patient's medical record.
- According to stakeholders, some aspects of required documentation are redundant
- Additionally, current documentation requirements may not account for changes in care delivery, such as a growing emphasis on team-based care, increases in the number of recognized chronic conditions, or increased emphasis on access to behavioral health care.

Final Policies for E/M Visits Starting in 2019

For 2019 and beyond, CMS finalized the following optional but broadlysupported documentation changes for E/M visits, that do not require changes in coding/payment.

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For history and exam for established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.

Final Policies for E/M Visits Starting in 2019 (cont.)

- Additionally, we are clarifying that for chief complaint and history for new and established patient office/outpatient visits, practitioners need not re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

Policies for E/M Office/Outpatient Visits Starting in 2021

- Beginning in CY 2021, CMS will implement payment, coding, and additional documentation changes for E/M office/outpatient visits, specifically:
  - Single rates for levels 2 through 4 for established and new patients, maintaining the payment rates for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;
  - Add-on codes for level 2 through 4 visits that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care;

Policies for E/M Office/Outpatient Visits Starting in 2021 (cont.)

- A new "extended visit" add-on code for level 2 through 4 visits to account for the additional resources required when practitioners need to spend additional time with patients.
- For level 2 through 5 visits, choice to document using the current framework, MDM or time;
  - When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary (typical CPT time for code reported, plus any extended/prolonged time).
  - When using current framework or MDM to document, for level 2 through 4 visits CMS will only require the supporting documentation currently associated with level 2 visits.

Documenting Using Time

Code(s)	Required Time (minutes)	Estimated Payment
99212	10	$90
99213	15	$90
99214	25	$90
99215	40	$148

Documenting Using Time (cont.)

Code(s)	Required Time (minutes)	Estimated Payment
99212 extended (99212 + GPRO1)	34-69	$157
99213 extended (99213 + GPRO1)	34-69	$157
99214 extended (99214 + GPRO1)	34-69	$157
99215 prolonged (99215 + 99354-5)	70+	$281+

Estimated Payment Beginning 2021 for Office/Outpatient E/M Visits

Level	Current Payment* (established patient)	Estimated Payment beginning 2021**
1	$22	$24
2	$45	$90 ($103 for primary care and non-procedural care)
3	$74	
4	$109	
5	$148	$148

* Current Payment for CY 2018

**Estimated Payment based on the CY2019 finalized relative value units and the CY2018 payment rate

Estimated Payment Beginning 2021 for Office/Outpatient E/M Visits (cont.)

Level	Current Payment* (new patient)	Estimated Payment beginning 2021**
1	$45	$44
2	$76	$130 (or $143 for primary care and non-procedural care)
3	$110	
4	$167	
5	$211	$211

* Current Payment for CY 2018

**Estimated Payment based on the CY2019 finalized relative value units and the CY2018 payment rate

Virtual Care

Advancing Virtual Care

- In response to the CY 2018 PFS Proposed Rule, we received feedback from stakeholders supportive of CMS expanding access to services that utilize technological developments in healthcare.
- We are interested in recognizing changes in healthcare practice that incorporate innovation and technology in managing patient care.
- We are aiming to increase access for Medicare beneficiaries to these services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology.

Advancing Virtual Care (cont.)

To support access to care using communication technology, we are finalizing policies to:

- Pay clinicians for virtual check-ins – brief, non-face-to-face assessments via communication technology.
- Pay clinicians for remote evaluation of patient-submitted photos or recorded video.
- Pay Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for these kinds of services - outside of the RHC all-inclusive rate and the FQHC Prospective Payment System rate.

Advancing Virtual Care (cont.)

- Expand Medicare telehealth services to include prolonged preventive services.
- Implement policies from the Bipartisan Budget Act of 2018 for telehealth services related to ESRD patients receiving home dialysis and beneficiaries with acute stroke, and implement SUPPORT for Patients and Communities Act policy to expand telehealth services for treatment of opioid use disorder and other substance use disorders

Discontinue Functional Status Reporting Requirements for Outpatient Therapy

- Discontinue the functional status reporting requirements for services furnished on or after January 1, 2019.

- PTs, OTs, and SLPs will no longer have to select and report FLR codes and modifiers (e.g., HCPCS codes G8978 through G8999 and G9158 through G9186, and severity modifiers CH through CN) in order to receive reimbursement.

Quality Payment Program: Merit-based Incentive Payment System (MIPS) Year 3 (2019) Final

Quality Payment Program: Merit-based Incentive Payment System (MIPS) Year 3 (2019) Final

MIPS Eligible Clinician Types:

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Register Nurse Anesthetists
- Groups of such clinicians

Year 3 (2019) Final

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists
- Audiologists
- Registered Dieticians or Nutrition Professionals

QPP: MIPS Year 3 (2019) Final

Low-Volume Threshold Determinations:

1. Added a third element – Number of Services – to the low-volume threshold determination criteria
    - The finalized criteria include:
        - Dollar amount - $90,000 in covered professional services under the Physician Fee Schedule (PFS)
        - Number of beneficiaries – 200 Medicare Part B beneficiaries
        - Number of services (*New*) – 200 covered professional services under the PFS
2. Added an opt-in option for Year 3
    - If you are a MIPS eligible clinician and meet or exceed at least one, but not all, of the low-volume threshold criteria, you may opt-in to MIPS
    - If you opt-in, you'll be subject to the MIPS performance requirements, MIPS payment adjustment, etc.

QPP: MIPS Year 3 (2019) Final

Performance Category Weights:

Performance Category	Performance Category Weights		
	Year 1 (2017)	Year 2 (2018)	Year 3 (2019) – Final
 Quality	60%	50%	**45%**
 Cost	0%	10%	**15%**
 Improvement Activities	15%	15%	**15%**
 Promoting Interoperability	25%	25%	**25%**

QPP: MIPS Year 3 (2019) Final

Performance Categories – Additional High-Level Changes:

Quality: Removed certain measures as a part of the Meaningful Measures Initiative and shifted the small practice bonus (worth 6 points) from the final score calculation into this performance category

Cost: Added 8 new episode measures

Facility-based quality and cost measures: Clinicians who are hospital-based can use their hospital's performance under the Hospital Value-Based Purchasing (VBP) Program for the MIPS quality and cost performance categories

Improvement Activities: Refinements made to the Improvement Activities inventory

Promoting Interoperability: Overhauled the category to simplify, focus on interoperability, align clinician policies with hospital policies, reduce measures, and change scoring to be focused on performance

QPP: MIPS Year 3 (2019) Final

Submitting Data:

Collection type- a set of quality measures with comparable specifications and data completeness criteria, as applicable, including, but not limited to: electronic clinical quality measures (eCQMs); MIPS Clinical Quality Measures* (MIPS CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures

Submission type- the mechanism by which a submitter type submits data to CMS, including: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface

- The Medicare Part B claims submission type is for individual clinicians or groups in small practices only to continue providing reporting flexibility

Submitter type- the MIPS eligible clinician, group, virtual group, or third party intermediary acting on behalf of a MIPS eligible clinician, group, or virtual group, as applicable, that submits data on measures and activities under MIPS

*The term MIPS CQMs ~~would~~ replaces what was formerly referred to as "registry measures" since clinicians that don't use a registry may submit data on these measures

QPP: MIPS Year 3 (2019) Final

Performance Threshold and Payment Adjustment:

Performance Period	Performance Threshold	Exceptional Performance Bonus	Payment Adjustment*
Year 1 (2017)	3 points	70 points	Up to +4%
Year 2 (2018)	15 points	70 points	Up to +5%
Year 3 (2019) - Final	**30 points**	**75 points**	**Up to +7%**

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

Quality Payment Program: Advanced Alternative Payment Models (APMs) Year 3 (2019) Final

General:

- Increased the Advanced APM CEHRT threshold so that an Advanced APM must require that at least **75%** of eligible clinicians in each APM Entity use CEHRT
- Extended the 8% revenue-based nominal amount standard for Advanced APMs through performance year 2024
- Streamlined the definition of a MIPS comparable measure

MIPS APMs and the APM Scoring Standard:

- Reordered the wording of the criterion to state that the APM "bases payment on quality measures and cost/utilization" to clarify that the cost/utilization part of the policy is broader than specifically requiring the use of a cost/utilization measure
- Updated the MIPS APM measure sets that apply for purposes of the APM scoring standard

QPP: Advanced APMs Year 3 (2019) Final

All-Payer Combination Option:

- Increased flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program
  - Established a multi-year determination process where payers and eligible clinicians can provide information on the length of the agreement as part of their initial Other Payer Advanced APM submission, and have any resulting determination be effective for the duration of the agreement
  - Allowing QP determinations at the TIN level in addition to the APM Entity and individual eligible clinician levels in certain instances when all eligible clinicians who have reassigned their billing rights to the TIN are included in a single APM Entity
  - Permitting all payer types to be included in the 2019 Payer Initiated Other Payer Advanced APM determination process for the 2020 QP Performance Period
- Increased the CEHRT use criterion threshold so that in order to quality as an Other Payer Advanced APM as of January 1, 2020, CEHRT must be used by at least 75% of eligible clinicians in the other payer arrangement
- Maintained the revenue-based nominal amount standard for Other Payer Advanced APMs at 8% through performance period 2024

Request for Information on Price Transparency

Price Transparency

Under current law, hospitals are required to establish and make public a list of their standard charges.

In an effort to encourage price transparency by improving the public accessibility of price information, CMS included a Request for Information related to price transparency and improving beneficiary access to provider and supplier charge information in the CY 2019 PFS proposed rule.

Price Transparency – January 1, 2019

Hospitals will be required to “make available a list of their current standard charges via the Internet in a machine readable format and to update this information at least annually, or more often as appropriate.

This could be in the form of the chargemaster itself of another form of the hospital’s choice, as long as the information is in machine readable format.

Frequently Asked Questions Regarding Requirements for Hospitals To Make Public a List of Their Standard Charges via the Internet

Q. What format is a hospital required to use to make public a list of their standard charges via the Internet?

A. The format is the hospital's choice as long as the information represents the hospital's current standard charges as reflected in its chargemaster.

Q. Do the requirements apply to all items and services provided by the hospital?

A. The current requirements apply to all items and services provided by the hospital.

Frequently Asked Questions Regarding Requirements for Hospitals To Make Public a List of Their Standard Charges via the Internet

Q. Do the requirements restrict a hospital from posting quality information or additional price transparency information?

A. CMS encourages hospitals to undertake efforts to engage in consumer friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain at the hospital, and to enable patients to compare charges for similar services across hospitals. A hospital is not precluded from posting quality information or price transparency information in addition to its current standard charges in its chargemaster.

Frequently Asked Questions Regarding Requirements for Hospitals To Make Public a List of Their Standard Charges via the Internet

Q. What is the definition of “machine-readable” for purposes of the requirements?

A. By definition, machine readable format is a digitally accessible document but more narrowly defined to include only formats that can be easily imported/read into a computer system (e.g., XML, CSV). A PDF, on the other hand, can be a digitally accessible document but cannot be easily imported/read into a computer system.

Frequently Asked Questions Regarding Requirements for Hospitals To Make Public a List of Their Standard Charges via the Internet

Q. What hospitals are required to make public a list of their standard charges via the Internet?

A. In the FY 2015 IPPS/LTCH proposed rule and final rule (79 FR 28169 and 79 FR 50146, respectively), CMS noted that section 2718(e) of the Public Health Service Act, which was enacted as part of the Affordable Care Act, requires that each hospital operating within the United States, for each year, establish (and update) and make public (in accordance with guidelines developed by the Secretary) a list of the hospital's standard charges for items and services provided by the hospital. There are no hospitals operating within the United States with exemptions from this requirement under the current policy.

Frequently Asked Questions Regarding Requirements for Hospitals To Make Public a List of Their Standard Charges via the Internet

Q. Does participation in a state online price transparency initiative satisfy the federal requirements?

A. CMS is fully supportive of and encourages state price transparency initiatives. However, under the current guidelines, participation in an online state price transparency initiative does not exempt a hospital from the requirements.

For Further Information

See the Physician Fee Schedule website at:

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

Questions?

Thank You

Renee Richard
Renee.richard@cms.hhs.gov