Physician Fee Schedule Final Rule: Understanding 3 Key Topics Call

Moderated by: Nicole Cooney
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Table of Contents

At this time, I would like to welcome everyone to today's Medicare Learning Network® event.

All lines will remain in a listen only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time.

I will now turn the call over to Nicole Cooney. Thank you. You may begin.

Announcements & Introduction

Nicole Cooney: Hello. I'm Nicole Cooney from the Provider Communications Group here at CMS and I'll be your moderator today.

I'd like to welcome you to this Medicare Learning Network list – Medicare – Learning Network call on the Physician Fee Schedule Final Rule: Understanding 3 Key Topics.

Before we get started, you received a link to today's presentation in your confirmation email. The presentation is available at the following URL go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

Today's event is not intended for the press and the remarks are not considered on the record. If you are a member of the press, you may listen in. Please refrain from asking questions during the Q&A session. If you have inquiries, you may contact press@cms.hhs.gov.

At this time, it is my great pleasure to introduce our CMS administrator, Seema Varma, who will provide opening remarks. Administrator Verma?

Presentation

Seema Verma: Thank you, and good afternoon. I appreciate everybody joining the call today. And I'm glad that I was able to make the schedule work because I'm very excited to talk about what we've been able to accomplish in our past final – final rule.

You might remember – because I certainly do – that when we introduced our proposed physician fee schedule rule, it was met with a lot of discussion, especially around our proposed changes to office visit E/M coding, and this is exactly what we wanted to happen.

As many know, I traveled the country over the last year and a half. And one of the things that I've heard time and time, again is how E/M coding is too burdensome. I also know that attempts to reform this burden have failed in the past, due to an inability for the stakeholder community and CMS to come together on an alternative.

Well, this time, inaction was not an option. And I'm appreciative of all the feedback from stakeholders like yourself that we received after our proposed rule was released. That feedback led to this finalized rule.

This reform is a big achievement for this administration in advancing the goals of our "Patients over Paperwork" initiative to reduce unnecessary burden to allow providers to spend more time on their primary mission: improving their patients' health outcomes.

You might remember that our initial proposal was to collapse levels 2 through 5, while adding additional add-on codes for more complex visits.

After listening to your concerns, we will maintain a separate level of payment, level 5, for the most complex patient care, and we are also assigning equal value to add-on codes for primary and specialty care.

And we are also not finalizing certain aspects of the E/M proposal related to multiple procedure payment reduction, changes to physician expense calculation and separate treatment of podiatry.

While these are the first significant changes in 20 years, the work doesn't stop now. We are delaying implementation of this policy until 2021 to allow continued discussions with stakeholders, while providing assurance that relief will come. Physicians will see some immediate changes in 2019 that reduce burden and even more significant burden reduction starting in 2021 when the broader changes to the E/M framework take effect.

For example, for the first time, physicians will have a choice on how they document E/M office visits. They will have updated options to document, based on time or medical-decision making, or they can continue to use the current framework if that's easier for them.

We're also simplifying payments by establishing a single payment rate for levels 2 through 4 office visits, with one rate for new patients and another rate for established patients.

By doing this, physicians only now need to meet documentation requirements currently associated with level 2, visits allowing doctors to decide documentation is most important and eliminated – and eliminated unnecessary paperwork only used for billing purposes.

Our E/M reform is budget neutral, meaning that we didn't make these changes in order to save Medicare money. We are doing this for one reason and one reason only: to reduce burden on providers.

The final PFS rule is projected to save clinicians, not the federal government but clinicians $87 million dollars in reduced administrative costs in 2019. And more than $8 billion dollars over – I'm sorry – more than $0.8 billion over the next decade.

In total, we are also saving 7.1 physician – 7.1 billion hours in administrative time over 10 years starting in 2021. This is concrete action behind our pledge to put patients first.

Our final rule also represents a big win in terms of access to care in convenient and efficient ways by offering patients new choices and how they connect with their doctors and caregivers.

For the first time in 2019, so that's January, Medicare will pay doctors for virtual check-ins with their patients – virtual consultations between physicians, evaluation of remote pre-recorded images and video and an expanded list of telehealth services.

For too long, virtual health has been looked at – looked at as a rural health issue. But anyone that has experienced the challenges of getting around in an urban environment knows that virtual health will increase the quality of care for all Americans.

To that point, I think you will agree with me that Medicare has not always been known for keeping up to date with emerging technology. So, finding ways to make these services available to all of our seniors from a policy perspective is a huge accomplishment and a step in the right direction.

As part of our Patients Over Paperwork initiatives drive to reduce unnecessary burden our meaningful measures initiative, which focuses specifically on reducing unnecessary quality and performance measurements, while strengthening program integrity, patient safety and improve patient outcomes was also advanced in our calendar year final rules. We're also making refinements to our proposals for the quality reporting programs based on feedback from you.

But we are finalizing the bulk of what we proposed. As a result of these changes, providers will save 10s of millions of dollars as we remove dozens of measures that were either topped out or unnecessary.

CMS has also taken several steps to streamline and improve our audit because this is something that we heard a lot of complaints about. And these moves will ensure a better payment integrity while reducing the amount of audit burden on providers.

This is included on our focus on targeted probe and education, where providers are given three opportunities to have educational interventions to help them understand why their claims are denied before being referred for more intensive auditing or administrative actions.

Additionally, CMS is in the final stages of compiling a unified documentation manual where providers can go to one place to search for all a CMS' documentation requirements.

This is based on developed on – developed based on feedback from providers with our "Patients Over Paperwork" initiative and will greatly reduce provider burden by having a centralized repository where patients – where providers can find all the CMS' manuals in one place.

And, finally, before passing the call over to some of our subject-matter experts to answer your specific questions, I just want to thank you again for all of the work you've done to help us finalize these rules.

I have always said and will continue to say that the best ideas don't necessarily come from inside CMS' walls. We need your input, we need your experience, and we need your energy if we're all going to work together to strengthen Medicare so that it serves our beneficiaries well.

So, sincerely, thank you for the services you provide and for the expertise and leadership that you exhibit every day. And I hope you all have a great Thanksgiving. Thank you.

Nicole Cooney: Thank you, Administrator Verma.

Levels of E/M Visit and PFS Payments

We will start with some information on E/M with Ann Marshall from our Center for Medicare. Ann?

Ann Marshall: Thanks, Nicole. So, Administrator Verma gave a great overview of the provisions in the final rule regarding evaluation and management visits. And I'm just going to deep dive in just a little bit deeper by way of overview before we go into Q&A.

So, as you may know, physicians and other practitioners that are paid under their physician fee schedule bill for their office and outpatient E/M visit using a set of CPT codes. And these distinguish visits based on the level of complexity, the site of service and whether or not the patient is a new patient or established.

And there are three key components when selecting the appropriate code to bill. And these are the history, the physical exam and medical-decision making. And also, currently for visits that consists predominantly of counseling or care coordination, time can be used as a controlling factor to determine visit level.

Although providers must also carefully document the medical decision making and the activities that were performed. And there are currently five levels of E/M office outpatient visits under the CPT coding theme, and payment increases at each level.

The changes that we finalized in the rule apply primarily to office and outpatient visits. We took stakeholder feedback last year into account and decided that a phased-in approach to start with office outpatient visits would be best.

And so, starting in 2019, practitioners can use either the 1995 or 1997 guidelines, but we adopted several changes that starting in 2018 will not involve coding and payment changes.

And these are – for home visits, we eliminated the requirement to document the medical necessity of the home visit in lieu of an office visit. And then for history and exam for established patients, when relevant information is already contained in the medical record, practitioners can more simply focus their documentation on what is changed since the last visit, or pertinent items that is not changed and this will prevent the need to re-record a defined list of required elements that another practitioner or other staff may have already documented.

And in addition, for established patients for any part of the history, including the chief complaint, practitioners will not need to re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary.

And instead, they can simply indicate in the medical records that they reviewed and verified this information. Under current policy, this only applies for the review of systems and the past family social history, portions of the history.

And in the final rule, we expanded this starting in 2019 to apply to any part of this history, including the chief complaint.

The more substantial changes to documentation of office and outpatient visits will come in 2021, as they dovetail with some coding and payment changes that we will be making at that time.

As Administrator Verma mentioned, we will be adopting a single payment rate that is a weighted average of the current utilization for levels 2 through 4 visits. Although we will be maintaining a separate payment rate for level 5 office outpatient visits in order to better account for the needs of complex patients.

We will be adopting add-on codes for these level 2 through 4 visits that described the additional resources inherent in primary care and particular kinds of non-procedural specialized medical care, and also for level 2 through four visits we'll be adopting an add-on code to account for extended time.

The level 2 through 4 – 2 through 5 visits regarding documentation, we'll be allowing starting at 2021 a choice to document using either the current framework, medical decision-making or time.

When time is used to document, practitioners will only need to document the medical necessity of the visit and that the billing practitioner spend the required amount of time face to face with the patient.

When using the current framework or medical decision making to document because we will be combining the payment for level 2 to four visits, this enables us to adopt the policy where we will only require the supporting documentation currently associated with levels two visits, which as you may know is a very basic data set.

There are two slides in the presentation, slides 12 and 13, that show the require times with when and the associated payment rates – when the choice is made to document using time.

So, this is just a visual way to show the amount of time that must be spent by the billing practitioner with a patient when time is used to document the service.

In the first chart, the times for the base CPT codes are shown and those are the typical CPT times for the code. And then for levels 2 through 4 when the visit is extra-long an extended visit code will be reported along with the base code.

And finally, once the time feeling for level 2 through 4 extended visit is reached, the practitioner will report the level 5 CPT code and the existing prolonged face to face service code or codes as appropriate.

The next two slides if you're following in the presentation kind of circle back to payment. And these show the payment rates when time is not being used to determine the level of the visit. So, it is showing both for the current payment rate of estimated payments starting in 2021 for the treat – the three-tiered system.

So, the base level 2 through 4 visit, again, was – will be a weighted average of the current utilization and payments

And that will increase by $13 dollars for primary care visit or for non-procedural specialty care. And in some cases, both the primary care and the non-procedural care code could be billed for a total $116 dollars for a level 2 through 4 visit.

And then you see the payment there for the level 5 visit is estimated to stay at $148 dollars, which would be consistent with the current payment rate.

There are two slides there and the difference between them is one is for the rates for established patients. And the second one is the rates for new patients.

Now I'm going to turn it over to my colleague, Lindsey Baldwin, who's going to review the final policies for Advancing Virtual Care.

Advancing Virtual Care

Lindsey Baldwin: Great. Thanks, Ann. So, in response to the CY 2018 PFS proposed rules, we received feedback from stakeholders supportive of CMS expanding access to services that utilize technological developments in healthcare.

We are interested in recognizing changes and healthcare practice that incorporates innovation and technology and managing patient care. We're aiming to increase access for Medicare beneficiaries to those services that are routinely furnished via communication technologies, by clearly recognizing a discrete set of services that are defined by and inherently involves the use of communication technologies.

In order to support access to care using communication technology in the CY 2019 Physician Fee Schedule final rule, we finalized policies to make separate payments for both the brief communication technology-based service or virtual check-in and remote evaluation of recorded video and/or images submitted by an established patient.

We also finalized separate payment for inter-professional consultations between practitioners and for chronic care remote physiologic monitoring. We also finalized paying Rural Health Clinics and Federally Qualified Health Centers for these kinds of services.

Under traditional Medicare telehealth, we expanded the list of telehealth services to include prolonged preventive services. We also implemented policies from the Bipartisan Budget Act of 2018 for telehealth services related to ESRD patients receiving home dialysis and patients with acute stroke.

Additionally, through an interim final rule of comment period. We're implementing a provision from the Support for Patients and Communities Act that removes the originating site and geographical requirements and adds the home as a permissible originating site for telehealth services furnished – for purposes of treatment of a substance use disorder or a co-occurring mental health disorder on or after July 1st, 2019.

This provision had a 60-day comment period, which ends on December 31st. And with that I'll pass it off to my colleague, Adam Richards and the CCS team.

Adam Richards: Great. Well, thank you. And I just want to reiterate thank you all for joining us again today. So, I am on slide 9, if you're following along with the presentation.

One takeaway that I hope you all recognize fairly quickly on the Quality Payment Program side is that they're not a tremendous amount of changes to our policies in year three. That is, aside from our eligibility terminations, the overhaul promoting interoperability, performance category and really our introduction to have facility-based scoring.

As Administrator Verma mentioned earlier, we have listened to each of you and focused our attention on reducing participation burden, streamlining measures to improve patient outcomes, introducing new clinician types to the merit incentive-based and payment system side and identify – continuing to identify ways that we can continue to drive value with the Quality Payment Program.

So, with MIPS, or the Merit based-Incentive Payment System we are – we are continuing our gradual approach or implementing flexible options and using the authority afforded to us under the Bipartisan Budget Act 2018 to help clinicians, especially those in our small and rural practices, successfully participate in the MIPS' track.

One area of focus for us was expanding the definition of MIPS eligible clinician type. Previously, for the first 2 years of the program and it's 2017 and 2018 – physicians, physician assistant or nurse practitioners, clinical nurse specialist and certified registered nurse anesthetist were eligible to participate.

For year 3, which would be 2019 we are expanding our definition to include the same five types, plus Clinical Psychologists, Physical Therapists, Occupational Therapists, Speech Language Pathologist, Audiologist and Registered Dietitians or Nutrition Professionals.

And just a note, we had originally proposed to include Clinical Social Workers, but we did not finalize this clinician type for year 3.

So, moving on to slide 20, a couple of important additions on this slide. First, we have expanded our low-volume threshold criteria.

Remember, this is the standard that we use to determine if a MIPS-eligible clinician has sufficient volume to participate in MIPS during a given performance period.

Previously through the first two years of the program, low-volume threshold determinations were made based on the dollar amount a clinician billed and covered professional services under the physician fee schedule and the number of Medicare Part B beneficiaries that a clinician saw.

We are maintaining both of these elements and we are adding a third criterion, which is the number of services. So, when we say service, we are equating one professional claim line with positive allowed charges to one covered professional service.

And if anyone would like an example of that, feel free to ask during the open Q&A. I think it's sometimes helpful.

So quickly just to recap to be included in MIPS with 2019 performance period, a clinician must build more than $90,000 in covered professional services and physicians – under the physician fee schedule – tongue twister.

And they must also see more than 200 patients. And now, they must also provide more than 200 covered professional services. So, they must meet all three elements of the low-volume threshold.

Clinicians who do not meet the low-volume thresholds are excluded from MIPS in 2019. Now we have heard from many clinicians who are eager to participate in the program for the first two years but did not necessarily have the opportunity in the first two performance period to participate, either due to not exceeding the low-volume threshold or, in some cases, not being a MIPS eligible clinician type.

To address the low-volume threshold concern, we have expanded the threshold to help us finalize our opt-in policy for year 3, so we did add that third criterion, so it allows us to create the opt-in policy, which will give clinicians who would otherwise be excluded an opportunity to participate in MIPS.

As long as an individual clinician or group exceeds at least one, but not all of the low volume threshold criteria that I just covered, they may opt into MIPS.

It's important to understand that opting into MIPS is irrevocable. Any clinician who opts into MIPS will be subject to the MIPS performance requirements, the payment adjustments and all the other rules that go along with participating in MIPS.

I will just say quickly, we are looking for your feedback on how we will operationalize the opt-in policy. We have a few ideas in mind. But if you are interested in participating in one of our user testing or user research sessions, I encourage you to reach out directly to us to our email box cmsqppfeedback@ketchum.com, and we can repeat that, and it'll also be on the slide at some point.

Okay. Moving on to slide 22, these are the performance category weights. If you had joined us for our last MLN call, you'll understand that under the MIPS program, we assess the clinician's performance, based on the four performance categories listed on these slides.

Each performance category has an associated weight or value to a clinician's overall final score. Again, the Bipartisan Budget Act afforded us some additional leeway in setting the category weights for year 3.

So, we have finalized the Quality performance category at 45 percent, Cost at 15 percent, Improvement Activities at 15 percent and Promoting Interoperability at 25 percent for the 2019 performance year.

Moving on to the next slide, which I think is slide 22. I think I misspoke earlier.

As I noted, aside from the facility-based scoring and overhaul to Promoting Interoperability, we did not make substantial number of changes to the performance categories. For Quality, we've leveraged our meaningful measures framework and reviewed many of our current quality measures to ensure that we are identifying the high-priority areas for Quality measurement and improvement.

For the 2019 performance year, we are removing 29 quality measures, including those that are processed, duplicative or topped out. And we are adding 8 new measures for which include patient reported outcome measures.

Additionally, one of the other bigger challenges is that or one of the big changes – I'm sorry – is that we have moved the small practice bonus to the Quality performance category, rather than as a standalone addition to the MIPS final score.

For Cost very straightforward, we are adding 8 new episode-based measures in addition to the Medicare Spending per Beneficiary and total per capita cost measures for 2019.

As I mentioned, facility-based scoring, this allows for certain clinicians to have their Quality and Cost performance category scores, based on their hospitals' performance, under the Hospital Value-Based Purchasing program using the total performance score.

Essentially what we're saying here is that if – that MIPS eligible clinicians who are eligible for this option, include those who furnished 75 percent or more of their covered professional services in an inpatient hospital and on campus, outpatient hospital or an emergency room, and those are based on claims for a period prior to the performance period.

The same goes with groups. We say that 75 percent or more eligible – of eligible clinicians under the group's TIN must meet that same threshold to participate and benefit from facility-based scoring.

For the Improvement Activities performance category, no major changes. We just made some refinements to our activities inventory. So, we now have 118 improvement activities for 2019.

And for Promoting Interoperability, like I mentioned, this was the biggest changes we have overhauled this category to simplify and align with our hospital policies. We've also streamlined the category scoring by eliminating the previous based performance and bonus scores and moving to a new performance-based scoring at the individual measured level.

So on to the next slide, talking a little bit about submission. One question we often hear is, "How do I get my performance data to CMS?"

In the previous two years, we've used the term "submission mechanism" all inclusively when talking about the method by which data is submitted, who is submitting the data and the measures and activities that are coming through to us.

We found that this caused some confusion for clinicians and those submitting on behalf of clinicians. So, what we've done is clarified how we talk about data submission and we've broken this into three elements.

So, the collection type, the submission type and the submitter type. The way I like to remember these new clarifications is what is being collected? So, the collection type. How is the data submitted? So, the submission type. And who is submitting the data? So, the submitter type.

One important note on this slide, under the submission type for year 3, we are only allowing individual clinicians or groups in small practices. So those with 15 or fewer eligible clinicians with the opportunity to use the Medicare Part B claims submission type.

Okay. And on the next slide, and this is the final slide for me before I turn it over to Dr. Corey Henderson from the Center for Medicare and Medicaid Innovation.

Talking a little bit about the performance threshold and payment adjustment for MIPS, when we say performance threshold, what we mean is the number that we used to compare against the MIPS eligible clinician or a group's final score. And this will determine if the clinician or group receives a positive, negative or neutral payment adjustment.

So, for year 3, we have set the performance threshold at 30 points, which is a modest increase from the two performance periods. We have also raised the threshold to receive an additional adjustment for exceptional performance to 75 points.

One area that I do want to be very clear on is the potential associated payment adjustment for 2019, which would be applied in the 2021 payment year. So, in MIPS eligible clinician could receive up to a positive seven percent or as low as a negative seven percent payment adjustment.

However – and this is the most important part. We must ensure budget neutrality under the law, which means that the payment, the MIPS payment adjustment factors are likely to be increased or decreased, depending upon the overall performance of MIPS eligible clinicians.

We saw these adjustments for the 2017 performance period. And if you have not already done so, I encourage you to read Administrator Verma' blog on the 2017 Quality Payment Program performance data results, as well as review our data infographic on qpp.cms.gov.

And with that, I'm going to turn it over to Dr. Henderson to talk about the changes to the Alternative Payment Model side of the program.

Alternative Payment Model

Dr. Corey Henderson: So as Adam just stated, there the second side to the program. We operate as one, but there is an Alternative Payment Models side to Quality Payment Program.

Our focus today are the advanced APM policies and MIPS APM policies. There are only a few. I stand – I stand between you and being able to ask questions. So, I will breeze through these, but try to get them succinctly and completely.

So, the first one is we are going to increase the advance APM search threshold so that the advanced APM must require that, at least, 75 percent of eligible clinicians, and each APM entity use CEHRT, and that is an increase from the previous 50 percent.

We extended the eight percent revenue base nominal amount standard for advanced APMs comes through performance year 2024, so that remains the same.

We streamline the definition of a MIPS comparable measure, we remove some of the burden, some portions of what we mean by MIPS comparable measures so please look that up.

From the MIPS APM side and the APM scoring standard, we reordered the wording of the criterion to state that the Alternative Payment Model bases payments 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.

So, we just reword it, and move some things around to got – kind of – give some more clarity there. We updated the MIPS APM measure sets that apply for purposes of the APM scoring standard.

And in addition to that, we looked at the all payer combination option and many people were excited about this because, we included and the all payer combination option, the other payer advanced APMs for non-Medicare payers to participate in the Quality Payment Program so that more clinicians will be able to make the qualifying participant or the QP threshold.

So, we establish a multi-year determination process when 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. We're allowing QP determinations at the TIN level and addition to the APM entity and individual clinician levels, in certain instances where eligible clinicians who have reassigned their billing rights to the TIN are included in a single APM identity.

And there, we're permitting all payer types to be included in the 2019 payer initiated other payer advanced APM determination process for the 2020 QP performance period.

And finally, the last 2 pieces are we increase the CEHRT use criteria threshold so that we align ourselves as the other payer advanced APM portion and starting January 1st, 2020, that CEHRT must also be used from the all their other payer side of the – of the advanced APM, to also be at least 75 percent of eligible clinicians and the other payer advanced APM arrangement.

And then finally, we maintain the revenue-based standard under the nominal amount standard for other payer advanced APMs at 8 percent through performance period 2024.

And with that, I will pass it back over to Nicole Cooney.

Question & Answer Session

Nicole Cooney: Thank you very much. Before we get started on today's Q&A session, I'd like to send few ground rules.

If you join us for our proposed rule call, you're familiar with this fun, and in an effort to get to as many participants as possible today, we're going to limit to about three minutes on each question and answer, and that really helped

us to hear from as many folks on the last call. And so we're going to do that again, because we do have many folks on the line with us today.

Today's call is not the forum for specific questions or casework about your medical practice or place of business. Please keep your questions related to the material discussed during today's presentations. And as a reminder, today's session is being recorded and transcribed.

All right, Dorothy, we're ready to get started.

Operator: To ask a question, press star followed by the number one on your touch tone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset before asking your question to assure clarity. Once your line is open, state your name and organization.

Please note your line will remain open during the time you're asking your question, so anything you say, or any background noise will be heard in the conference. If you have more than one question, press star one to get back into the queue and we will address additional questions as time permits. Please hold while we compile the Q&A roster.

Please hold while we compile the Q&A roster.

Your first question comes from the line of Ruth Cornwall.

Ruth Cornwall: Hi, this is Ruth Cornwall with the Kansas Medical Society. Thank you for the opportunity to visit with you today, I appreciate all the work that CMS staff has put into this. I understand that there were thousands upon thousands of comments that – I have a couple of comments and concerns.

First of all, as I read the final rule, I think there's a great deal of clarifications that need to be made, to better understand and would ask this clarification come from CMS and not be left for interpretation of the MACs, as it needs to be consistent across the board.

For example, in the era of transparency with the efforts that CMS is putting forward and the targeted probe and educate, the MACs should be – should make their audit E/M tool available to the providers.

With respect to the office outpatient visit starting in 2019, there's a section that speaks to for established patient history and exam 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.

I think we need to clarify whose documentation that is. Can it be – does it need to be the same provider, a provider within the group, provider in the same health system?

I think that would help, at least, with some of the questions I'm getting from our members here in Kansas. Also, how will this affect, or will it affect the resident supervision guidelines?

Ann Marshall: Thanks for the feedback and the questions, I have had someone else asked the same question on 2018 documentation piece that you asked.

And we have already drafted an FAQ that will be out shortly on the other piece that you didn't ask about the ancillary staff, but I think that an FAQ on this question that you asked would also be helpful. And we will – we will try to work on that.

Ruth Cornwall: Great. Thank you.

Nicole Cooney: Thank you.

Operator: Your next question comes from a line of Ronald Hirsch.

Ronald Hirsch: Hi there. My question is about the virtual check-in. The rule states that the patient must give consent, but it's unclear if they're giving consent to have the phone call or interaction or they're giving consent for the practitioner to be able to bill Medicare?

And if it is to build Medicare, and the patient says, "No, I don't give consent," should the physician just hang up on the patient or do they have to then give away their services for free and continue the call?

Lindsey Baldwin: Hi, thanks for your question. Right. The issue of consent to it would be about whether or not you could bill Medicare for that service. We thought that was important, particularly since this is a service that, perhaps, patients may have received in the past and did not have any copay.

So how the practitioner would choose to handle the situation when the patient does not give their consent would certainly be up to their clinical judgment. Hope that answers your question.

Ronald Hirsch: Yes, thank you.

Operator: Your next question comes from the line of Dale Gibson.

Dale Gibson: My question has been asked. Thank you.

Operator: Your next question comes from the line of Karen Willett.

Karen Willett: Good afternoon. I'm calling from Indiana University Health.

My question has to do with the virtual care. I noticed on the CMS website yesterday that the only codes that are listed as being updated for 2019 for telemedicine are the prolong preventive services and I was wondering if you had a projected date where the virtual care codes that are – were mentioned on today's presentation – the other codes would be released?

Lindsey Baldwin: Hi, this is Lindsey Baldwin answering your question. If I understand you correctly, I think you are saying that you did not see codes G2010 and G2012 on the list of eligible in Medicare telehealth services. Is that right?

Karen Willett: Yes.

Lindsey Baldwin: Yes. So that is correct, because these codes are actually not subject to the restrictions in Section 1834 and that all of those services on the Medicare telehealth list are subject to.

For example, the …….

Karen Willett: Oh, Okay.

Lindsey Baldwin: geographic – yes, the geographic requirements that particular healthcare settings, these services would be open to, for example, any geographic area just like any other code on the fee schedule.

Karen Willett: Okay, good. Thank you

Lindsey Baldwin: Sure.

Operator: Your next question comes from the line of Susan Cook.

Susan Cook: Hi. This is Susan Cook with Freeman Health System in Joplin, Missouri.

I have a question about HPI. And during the presentation we're talking about anyone could document the chief complaint and the provider would just have to validate that.

Our local MAC has already stated that anyone could document the chief complaint. We just need validation.

But I am concerned about the HPI. Is the provider going to be the only one who can document HPI beginning January 1 of 2019? Or is this – is HPI encompassed in the changes that CMS is going to make into effect?

Ann Marshall: Hi, this is Ann Marshall. So, thanks for the question. Again, we – we'll be issuing an FAQ that, I think, will help to clarify a little bit about this.

But I think it's helpful to note that the terminology gets a little bit tricky here. In the 1995 and 1997 guidelines include the chief complaint review systems and a PSSH as components of history that can be included in the description of HPI or be separate.

So, I think it's a bit tricky whether HPI is really a completely separate thing from these other pieces. And really in terminology, land there, there could be overlap.

So, what we are saying here, however, is that the chief complaint and any part of the history, if it is already documented by ancillary staff, or recorded by the beneficiary, and already in the medical records does not need to be re-documented by the billing practitioner and instead they can just perform the verification and supplement it as necessary.

This is not a — a verdict on who can or cannot perform history or the most critical parts of it and whether or not they're qualified to perform a history or take it or all of it independently?

I don't – I don't think that we read the current manual provision or guidelines as even addressing that. This is simply about what's the – and preventing the billing practitioner from having to re-document information that's already been appropriately documented by someone else in the records. Is that helpful?

Susan Cook: Okay. No, not really because our MAC has a directive is in place right now that says only the provider can document HPI, the ancillary staff cannot document it.

Ann Marshall: Right. We understand that that this is a change from current policy and we expect that the MACs should be updating their policies accordingly.

Susan Cook: Okay. All right. Thank you.

Operator: Your next question comes from the line of Misty Chance.

Misty Chance: Hi. This is Misty Chance, I'm with Evolution Consultants. I have three simple questions.

The first has to do with setting the allowable for that level 2 through 4 reimbursements. You guys had said a weighted utilization.

I'm wondering if that is a CMS-wide utilization or if that is a provider-specific utilization that sets that rate?

My question number two is when the 2019 quality measures will show up on QPP. And my final question is we have situations in which – and the provider is eligible for QPP, or MIPS, underneath their previous TIN, but they are no longer working with that TIN for reporting purposes and they are not eligible under their new TIN, would there be penalties associated with this or is this truly the NPI TIN combination?

Emily Yoder: Hi. So, this is Emily Yoder and I will address your first question about the payment rate – the CY 2021 payment rate for the levels 2 through 4 office outpatient visits.

We develop that blended payment rate using five years of Medicare claims data weighted by utilization for those services.

Misty Chance: Okay.

Adam Richards: And this is Adam Richards. So, for your first question, we will or we are aiming to have the 2019 quality measures. There're also other specifications for promoting interoperability and improvement activities available on qpp.cms.gov toward the beginning of the 2019 performance period so in a few weeks.

And for your third question, could you just repeat that one more time for us?

Misty Chance: So, I have providers who when you look at their MPI for reporting eligibility, they are eligible to report under their previous tax ID. However, they no longer work for those tax ID numbers and have no access or control over whether or not that data gets reported.

However, for their new practices, they would easily hit a threshold, a low volume threshold or any of the categories. So how do they report? And if they do not report data, then are those penalties? Is that truly a tax ID NPI combination?

So, if that data is not reported under their old TIN, their new claims moving forward that are under their existing individual NPI and TIN, would those be assessed the same penalty?

Adam Richards: And is this – or this particular clinician, this is for the same performance period?

Misty Chance: Well, they've left – I've got several of them actually who are kind of in between where they left one group, let's say, August and they were eligible to report from January to August but did not perform enough services under their new TIN to be eligible to report in that year?

Adam Richards: Okay, yes. I think this is one of those scenarios where we should work through this with the service center. Have you reached out to us before?

Misty Chance: I have. I have a slew of service tickets put in, but I sent in to fall in between the fact that the penalties that I'm seeing were from the, I call it, old school, meaningful use, compared to the new MIPS. And so, I'm just kind of in this "No Man's Land" of nobody can really answer this question.

Nicole Cooney: Give us one second.

Adam Richards: So, I think we're going to do here is since this is one of those unique scenarios, I'm going to connect with you offline and we can …

Misty Chance: Okay.

Adam Richards: … and then I'll help you try to get this all sorted out, we'll get you to the right people.

So, if you could just – if you have an email address that you could – email address or phone number

Dr. Corey Henderson: If you give us a moment, we want to respect your privacy and not give your information out across 2- 3,000 people.

Nicole Cooney: Let – yes. Let me – let me give – let me do this. I have a resource box that I personally check so I know you will – you won't get lost in the shuffle.

If you could send your question your contact information to MLN, that stands for Medicare Learning Network – MLNeventsteam@cms.hhs.gov. I will make sure it gets to Adam.

Misty Chance: To that is MLN events with a plural S team

Nicole Cooney: Yes.
Misty Chance: … @cms. What was the last part?

Nicole Cooney: Dot H-H-S dot G-O-V.

Misty Chance: Perfect, will do.

Dr. Corey Henderson: And please do include any of your ticket number so we can – try to make sure we don't do a duplicative effort here.

Adam Richards: That would be helpful. Yes.

Misty Chance: Okay. Thank you.

Nicole Cooney: Okay.

Adam Richards: Okay, thank you.

Nicole Cooney: Thank you. And, Dorothy, before we go to our next question, I just want to take a minute. I may not have said this at the beginning, but we really do – in addition to trying to respect the three minutes per exchange of really, if you could limit your questions to just one, that would help us.

We do have a lot of folks in queue and a lot of folks on the line, so I'm really trying to get to as many as possible. So, we'll take the next one, Dorothy.

Operator: Your next question comes from a line of Margaret Reina.

Margaret Reina: Hello. This is Margaret Reina. I'm with Tulane University Medical Group. I think some of my questions could be answered by the FAQ that's coming out.

But I have one specific question about both the chief complaint and the area of history and exam when a provider reviews from previous documentation or someone else has provided that documentation. It says that provider must verify or there must be evidence that the practitioner reviews the previous information updated – needed.

The verification have to be explicitly stated. Can that be found in the audit trail of the electronic medical record that they looked at it? I'm not sure how – what the evidence of the practice reviewing what that means exactly in terms of documentation.

Ann Marshall: Hi this is Ann Marshall. Thanks for the question. I think we will have to take that back to our Center of Program Integrity folks and see if there's anything further that the agency wants to say on that.

At this point in time, we have not been more specific. I know that when we issue changes for – related to medical student documentation earlier this year that the Center for Program Integrity put out an instruction sort of expanding a bit on what was meant by the term verify.

I think that where they landed was basically a signature in the record. But whether or not we want to take that approach here and be more specific is a question that we'll take under advisement and think some more about.

Nicole Cooney: Thank you.

Margaret Reina: Thank you.

Operator: Your next question comes from a line of Robert Jarrin.

Robert Jarrin: Great. Hi there. My name is Robert Jarrin; I'm with Qualcomm Incorporated.

My question is that the descriptor for a newly activated physiologic remote patient monitoring CPT code 99457 specifies clinical staff position or other qualified healthcare professional time.

In the comment response from the final rule, CMS tries to clarify that CPT code 99457 describes professional time and, therefore, cannot be furnished by "auxiliary personnel" incident to a practitioner's professional services.

My question is who exactly is auxiliary personnel? And are they the same as clinical staff? If so, who then can bill CPT 99457, only physicians qualified healthcare professionals? What about clinical staff that are specifically mentioned in CPT code 99457? Thank you.

Emily Yoder: Hi, this is Emily Yoder. Thank you so much for the question and for bringing this to our attention.

We understand your question and we're actually looking into it. You're not – you're certainly not the first person who has brought this up. So, we're looking into it, and if we determine that the language was an error, we would usually address this through a technical correction notice. Thank you.

Robert Jarrin: Great. Thank you very much. Appreciate it.

Operator: Your next question comes from a line of Jennifer Palowski.

Jennifer Palowski: Hi, this is Jennifer Palowski from Delaware Valley ACO. I'm calling in reference to slide 25. And the requirement that ACO – this looks like advanced APMs required that, at least, 75 percent of eligible clinicians in the entity use Certified EHR Technology.

I believe I read also that that applies for MIPS APM, but maybe at a different percentage. And my question has to do with how this will be reported. So, will the ACO have to report something or will this be calculated somehow without direct submission? Thank you.

Dr. Corey Henderson: So that reporting, it will be 75 percent. And that reporting is done at the entity level. So, if you are in an ACO, then you're speaking from a full TIN models, specifically the Shared Savings Program, is that correct?

Jennifer Palowski: Yes.

Dr. Corey Henderson: You said yes?

Jennifer Palowski: Yes.

Dr. Corey Henderson: Okay, yes. So the Shared Savings Program also has additional policies about how they report up through the ACO from the different TINs.

So, each of that will be captured in – each of those different policies will be captured also, specific to how the ACO reports. But they usually report everything together under the entity but separately for a different policy. They're promoting interoperability is a little different, where they allow for you to report individually or as a group.

So, there's additional information out there and you can find on gpp.cms.gov, additional webinars and information about that.

Jennifer Palowski: All right. Thank you.

Operator: Your next question comes from a line of Janet Brier:

Janet Brier: Hi. Thanks again for doing this. I just have a quick question about the number of services. The 200 covered professional services under PFS, do the global visits counts for that 200?

Emily Yoder: I'm sorry, this is Emily Yoder. Could you say a little bit more about these 200 services? Which services are you referring to?

Janet Brier: Yes. If someone has a – if someone has a surgery, some of the – they're in a global period and there are some non-billable visits during that period. Do they count towards the 200?

Adam Richards: It would so. The – what we say as a …

Janet Brier: And if so, that they wouldn't be paid.

Adam Richards: Right. So, this – sorry, this is Adam Richards. So, what we're saying is a services one professional claim line with positive allowed charges to one cover professional service.

Janet Brier: So – but these are none – these – there's no charge for these. They're in the global period post-surgery. So, do it – do they count towards the 200 is the question.

Dr. Corey Henderson: I think we just need to verify that because we believe that …

Janet Brier: Yes.

Dr. Corey Henderson: … the policy is stating irrespective of whether or not it's a billed and there's a pay.
Janet Brier: Okay

Dr. Corey Henderson: Where the policy says that number of services specifically covered under the PFS, it doesn't say that had to be a certain billable amount. So we just need to verify that and again …

Janet Brier: And these would never be billed. But they would be reported as a claim as – in the global period post-surgery.

Dr. Corey Henderson: Yes, we can't make – we can't make interpretation for that policy – for any policy but we can state explicitly that it says covered services under the PFS. So, if it is a covered service and it is showing up on a claim, then we could suggest that specifically whatever the rule and policy states, we would support that.

So, you can also call or reach out through email to the service center and get clarification and we'll – also we monitor those.

Adam Richards: Yes. I will take this one back. So, it sounds like we're going to need an FAQ around this one. So that's something we can do. Make sure we get out there.

Janet Brier: Yes, because it's fairly common occurrence, you know. Thank you. Appreciate it.

Nicole Cooney: Thank you.

Operator: Your next question comes from a line of Julie Lundberg.

Julie Lundberg: Hi thanks for taking my call. My questions about advanced APM reporting requirements. So, we're understanding that there's the 75 percent CEHRT use.

And we're being told that other advanced APMs actually demonstrate this by having to report the PI category, right, which is devastating, which is one of the reasons doctors love the advanced APM, is they cannot admit that they even type their NPI's in and it says, "Guess what you don't have to report for MIPS."

But then there's like this little asterisk we were learning about that, "Oh, just kidding. If you're in an advanced APM – and we need you to demonstrate. We need to demonstrate that the 75 percent are using CEHRT. And we're going to have you do that by going ahead and reporting the PI category. Can you confirm if that's a requirement for every advanced APM, or is it just for the APOs?

Dr. Corey Henderson: So, which you're …

Julie Lundberg: That's my question.

Dr. Corey Henderson: No, it's Okay. What your speaking of is that there is a level policy, which I spoke to and briefly who was the qualified APM participant.
So the QP is also not required to do work at MIPS, because you're already doing the work in advance APM. And then in addition to that quickly, you receive a five percent bonus because you've met that level of work in the advanced APM.

So, the 75 percent requirement is actually for the entity, so that it may require if there is reporting let's say that it's a entity that is in a MIPS APM and advanced APM because the whole group, as long as it's all redoing the work under the Advance APM gets that QP status.

We do it at the entity level, then if there are still reporting requirements under the APM entity, because some participants are in MIPS, then in order to get the 75 percent, we don't want to exclude those persons.

So that again is done at the entity level and it's not stating that, "Hey, explicitly you have nothing to do," we're just putting the caveat that there may be someone coming to capture that data, so we just want to have that caveat out there, so its specific to what type of level you're in.

Julie Lundberg: So, right. So, I sent the questions to the BPCI advanced and haven't heard back yet. So, I guess that's really the specific question is that particular advanced APM will there be a requirement to have the individual PGP's report the PI category just to demonstrate the 75 percent CEHRT use.

Dr. Corey Henderson: Yes. And finally, just the quickly state that if your organization – it's entity is considered to be qualifying participants, then if everyone in your organizational entity is not reporting through MIPS, then we're not going to be checking for that because as a QP – again, the whole point is to try to exclude any additional burden.

So, if you find out through BPCI that you are a qualified participant, then that will not relate to you because we're not going to be looking for that data because there is no submission for QPs.

But if someone in your group or your entity has to submit, so they just need to make sure to 75 percent of the group is doing that work.

Nicole Cooney: Thank you so much for your question. In the interest of time, I need to move on. Dorothy, can I have our next question, please?

Operator: Your next question comes from the line of Melinda Welter.

Melinda Welter: Hi, this is Melinda Welter from Independent House. Thank you for taking questions.

Many of mine has been answered as it relates to looking for additional clarification on the office or outpatient visit.

But I was wondering how you'll be publishing the FAQ. Is that something that we'll get an email about or something we'd have to look on the website for?

Ann Marshall: Typically, we issue FAQs on the physician fee schedule Web page, so you can certainly look there. Sometimes we pushed it out through the MLN as well and we'll consider the best ways to issue – to issue it.

Melinda Welter: Okay. Thank you. I just don't want to miss it.

Operator: Your next question comes from the line of Lilian Mark.

Lilian Mark: Hi my name is Lilian from HonorHealth in Phoenix. I just have a quick clarification regarding the documentation for the HPI and the physical exam.

So effective January 2019, will the MACs be issuing an update to the HPI elements, as performed by the physician, such as location, quality, severity, duration, et cetera? I understand the whole ROF that the chief complaint can be part of the HPI.

But what about the other – the HPI actual elements, such as location, quality, severity, et cetera? Number one, and number two, the – if a physician copy and paste an entire exam for a previous visit, will that be allowed under the new guidelines for 2019?

Ann Marshall: Hi, this is Ann Marshall. So, on your first question, we expect the MACs to update their guidance as they always do whenever Medicare update policies, MACs are required to update their policies accordingly. Please let us know if that doesn't happen in your jurisdiction for some reason.

On your second question, I don't interpret anything in the final rule is allowing just a blanket copy and paste from a prior exam.

Lilian Mark: Okay. So, basically for the HPI elements, it will be updating. Our MACs will update where auxiliary staff can also ask the patient about the HPI, duration, quality, severity, and all that.

Ann Marshall: Your MAC should update its policy according to the guidance that CMS issued and will issue in the FAQ.

Lilian Mark: Okay, thank you.

Operator: As a reminder, if your question has been answered, and you would like to remove yourself from the queue, press the pound key. Again, that's pound to remove yourself from the queue.

Your next question comes from the line of Mark Devini.

Mark Devini: Yes, thank you. My name is Mark Devini. I work with Top Education. It's a consulting company to mostly physical therapists and chiropractors. And I'm going to apologize upfront for my question because it appears pretty superficial, but I just want to be clear.

In reference to slide 20, the new provision for the low threshold determination. You mentioned 200 covered professional services. And I want to make sure that means 200 individual line items, even though they may be the same CPT code because, as you know, chiropractors only have three CPT codes that they can bill Medicare for.

So, in – my question is very simply, is it 200-line items, even though they may be a repeat of the same CPT code?

Adam Richards: That's correct. I'm sorry.

Mark Devini: Thanks.

Adam Richards: This is Adam Richards.

Mark Devini: Thank you.
Nicole Cooney: Thank you.

Operator: Thank you. Your next question comes from a line of Ari Webzaramni.

Ari Webzaramni: Yes. Thank you for taking my question. First of all, I want to thank the entire CMS crew, I must say these conferences are a lot better than they used to be three or four years ago when – that really, the information is very confusing.

Having said that, I run a hospitalist group. We are 100 percent inpatient, and we have about 20 physicians.

In the past, we've submitted our MIPS data via claims through a registry, who then summarizes our claims data or the quality information that we give them. And then they submit the data for us as a group.

What that means is physicians end up submitting quality information twice, once into the EHR system at the hospital. And then when they submit the billing data, they, again, enter information regarding MIPS questions.

So, talk about paperwork, this definitely takes away from patient care because we're doing the same thing twice, just to meet MIPS guidelines.

So, my curiosity is raised by slide number 22, where facility-based quality and cost measures apparently is an option where we can use the Hospital Value-Based Purchasing performance, in lieu of submitting MIPS data all over again.

Now, my question is, we are a private group. We are not employed by the hospitals where our group goes, so are we still eligible for that hospital VBP option to submit MIPS data? Number one.

And then are we in a position to see that data before it gets submitted? Or is it data that is hospital-wide, not just relevant to our group, and, hence, we don't have access to it, which wouldn't work for us. We'd want the data to represent our group.

And, finally, our physicians go to multiple hospitals. So how would – how would you assign VBP performance data across hospitals to each physician?

Adam Richards: Okay, so this is Adam. That's a lot to take on. So maybe it's just best if I – do I have enough time to kind of just walk through facility-based scoring at a high level because I think it'll be helpful …

Nicole Cooney: Yes, sure.

Adam Richards: … context. Okay. So, yes, so facility based, it is that option where we will take your total – your total performance score from the Hospital Value-Based Purchasing program, and we'll use it for your quality and cost performance categories.

So, what this does is – again, I went over this a little bit earlier for the – to be at – to be in – to able to use facility-based scoring, the MIPS eligible clinician must furnish 75 percent or more his or her covered professional services, either in an inpatient hospital and on-campus outpatient hospital or an emergency room. Same would go with groups but you need 75 percent of those eligible clinicians billing under the TIN.

Now what we do as far as attribution and election goes, is what we do is for facility-based clinician, we would attribute that clinician to the hospital where they're providing the most or the – providing services to the most patients.

For facility-based group, we are – we are attributing to the hospital-related where they provide – where the facility-based clinicians are attributed.

The election is automatic. So, what that means is we automatically apply facility-based measurement in MIPS-eligible conditions and groups who are eligible for facility-based measurement and would benefit from having a higher combined quality and cost score.

There are no submission requirements for individual clinicians for facility-based measurement. But for a group, we would – the group would need to submit data for either the Improvement Activities or the Promoting Interoperability, performance categories as this would signal to us, that you wanted to participate as a part of a group.

I'm just – I'm trying to hit all of the questions. There was one question I know about how would this work across multiple hospitals. I think that's something that we would have to release in a – in an upcoming FAQ.

Just quickly want to touch on measurement because I think this is important as well. For facility-based measurements, the measure set for the fiscal year Hospital Value-Based Purchasing program that begins with are applicable in MIPS performance period would be used for facility-based clinicians.

So, for example, for the 2019 MIPS performance periods, that's a year three, the measures that we'd use for the 20 – we would use with – be for the 2020 Hospital Value-Based Purchasing program and the associated benchmarks and performance periods.

I know that's a lot. We will have resources coming on facility-based scoring shortly. We're working on that towards the beginning of the performance period.

Nicole Cooney: Thank you. Thank you, Adam.

Ari Webzaramni: Adam, what matter – is it matter if it's private or a employed group? We are not employed by the hospital. Does that matter?

Adam Richards: That I don't know. We'd have to follow up on that one in an FAQ.

Nicole Cooney: Okay.

Adam Richards: Private (inaudible) …

Dr. Corey Henderson: And this is Corey Henderson. I think some of the questions that you're posing, if you go to the federal rule in federal register, that's by around page 1330, you'll find your answer right there around 1336, specifically speaking to more than one facility and clinicians and how we are proposing to answer some of those questions and later rules.

Nicole Cooney: Thank you, Corey. Okay, I need – really need to move on to our next question in the interest of time. Thank you.

Operator: Your next question comes from the line of Lee Williams.

Lee Williams: Hello, Lee Williams. I just wanted to get confirmation on your 95 and 97 guidelines. Once they are updated, will they include specific language to state that the history change, as far as the history and exam by ancillary staff not having to be re-recorded.

Will it specifically say that that is specific to outpatient office or clinic? So that is not confused with the subsequent hospital visits. I just want to know what I'm doing my training. Do I need to specifically spell that out? Or is that going to be included in the update for the 95, 97 guidelines? Thank you.

Ann Marshall: Hi. This is Ann Marshall. The FAQ, just like the – I think the rule clarified this. If it doesn't, the FAQ, certainly will. That it's only for office outpatient E/M visits.

We don't own the 1995 and 1997 document guidelines documents themselves, but we will be updating our manual and any related guidance that CMS owns on this topic.

Lee Williams: Okay, thank you.

Operator: Your next question comes from a line of Erin Zelinski.

Nicole Cooney: Hello. Did you have a question?

Erin Zelinski: I do …

Nicole Cooney: (Crosstalk)

Erin Zelinski: Thank you so much for taking my call.

Nicole Cooney: That's Okay.

Erin Zelinski: I was actually calling because CMS has – and just even in this call alone, you guys talked about some new patient reported outcome measure quality measures, but they haven't actually been released on the QPP website.

Our particular group needs to have our selections made by early December for our EHR to add those quality measures to our MIPS report for 2019. So, are we going to be getting those details soon? Or will CMS allow less than 12 months of reportable data in 2019.

Adam Richards: So, thanks for the question. This is Adam. So yes, we will be releasing those quality measure specs very soon. We are targeting, in fact, the next couple of weeks because we do know that there is a 12-month reporting period for 2019. So yes, it will be out on qpp.cms.gov very shortly.

Nicole Cooney: Thank you.

Erin Zelinski: Will that be on an actual date or no?

Adam Richards: Unfortunately, no. Like I said, I – we are targeting we are pushing to get these through it's – as soon as we can, because we know we do have folks like you in certain situations where we do need this information out there.

So, we are aiming to have them out and like I said, I don't want to give you a date because it could fluctuate, but we are trying to get them out as soon as possible.

Erin Zelinski: Okay, great. Thank you, appreciate it.

Operator: Your next question comes from a line of Donna Kruger. Donna, your line is open.

There is no response from that line. Your next question comes from the line of Sally Jordan.

Sally Jordan: Yes, thank you. We are an FQHC and have a question about the virtual visit. Not the telehealth but where if the patient has had a visit in the prior 12 months, they can have a brief digital visit. Does that visit have to be with that patient's primary care provider? Or can it be with another nurse practitioner or another physician?

Corinne Axelrod: Hi, this is Corinne Axelrod. It can be with any FQHC practitioner in that particular FQHC.

Sally Jordan: Thank you

Corinne Axelrod: Welcome.

Operator: Your next question comes from the line of Deborah Hennessy.

Deborah Henessy: Yes, hi. I was wondering we are an MSSP ACO, and we are a multi-specialty hospital-based physician group. And in our group, we have outpatient physicians, as well as hospital-based physicians. How will our hospital-based physicians be eligible in the new MIPS? I know last year, they did not have to report will that be the same this year?

Dr. Corey Henderson: So that is a very specific question to the Shared Savings Program and how they attribute clinicians and capture their clinician's designation. So, I don't want to give an answer to that question because the Shared Savings Program also has some new policies that they're working on specific to the Shared Saving Program.

Deborah Henessy: Okay

Dr. Corey Henderson: So, I would I would just urge you to look at how the two kind of cross and probably reach out to our service desk and we also like that …

Deborah Henessy: Okay.

Dr. Corey Henderson: … we monitor those. But this specialist who does the Shared Savings Program is not in the room right now. So, I would rather under promise …

Deborah Henessy: Okay.

Dr. Corey Henderson: … than over deliver it…

Deborah Henessy: Absolutely.

Dr. Corey Henderson: … I tell you that I don't have the answer.

Deborah Henessy: Okay. All right. Thank you.

Female: Okay, yes.

Operator: Your next question comes from the line of Margaret Dener. Margaret, your line is open.

Margaret Steiner: Are you saying Margaret Steiner?

Nicole Cooney: Yes, did you have a ….

Margaret Steiner: Yes, if you're looking for Margaret Steiner, my – I'm from Group Health Cooperative of South-Central Wisconsin. And my question is related I know somebody asked it earlier but it's still not clear to me.

The third element for the low-volume threshold related to the number of services, 200 covered professional services under the PFS, if some examples could be given of that, that would be great or, potentially, where to go and look for further definition around that criteria.

Adam Richards: Sure. So, this is Adam again. You won't have to look too far. We are going to continue working on some. Our resources that are specific to cover – the new criterion for covered professional services. But let me just give you an example. This is one that we were using last week during our webinar.

So, if we think of a – as Medicare beneficiary, that person will likely have annual visit. Let's say the same Medicare beneficiary also sees a doctor or clinician for a sick visit a prescription refill, and maybe to discuss a known issue.

Over the course of the year, the doctor or the clinician, hypothetically, of course, provides four services to this beneficiary. So, the beneficiary is considered one unique patient, but in this example, the number of services would be four, so that would count toward that 200 covered professional services.

Margaret Steiner: Okay.

Operator: Your next question comes from the – your next question comes from the line of Cathy Archuleta.

Cathy Archuleta: Thank you. It would be helpful to know when we can expect the FAQs to be released, in particular clarification surrounding documenting the history elements, specifically the HPI.

Nicole Cooney: Give us one second.

Hi, this is Nicole. We will work on notifying the registrants for this call when FAQs are posted and that way we'll help you get connected to the information.

Cathy Archuleta: Thank you.

Operator: Your next question comes from a line of Jennifer Montgomery.

Jennifer Montgomery: Hi. This is Jennifer Montgomery. I'm from Mount Sinai Beth Israel in New York. I have a question about QPs and an advanced APM and how they're supposed to be paid. We – I understand that they don't have to submit MIPS.

But if they're in more than one – under one – more than one tax ID, and they qualify as a QP under one specific tax ID, is it true that the payment only goes to the one tax ID NPI combination? What happens to the other tax IDs that the provider might be under?

Dr. Corey Henderson: So, thank you. That's a great question. So, we just had a question like this come through the service center. And what we learned was that in just pulling from the rule – this is Corey Henderson.

One of the things we learned is that the tax identification number that receives the 5 percent bonus, often the clinician didn't understand that it's that one entity that they assign their billing to. You may be operating in more than one TIN or under one entity.

Once you receive QP status or qualifying APM status, that participation level and designation through the methodology was calculated with the other clinicians under that same entity.

So, we don't send the payment elsewhere because the work was done with the group that you did the work with. However, under the other TINs, they may require to capture information about what work you did with them only around the promoting interoperability or other areas where they just need to have the full groups work.

But you will not be required to report to MIPS under the others because the qualifying APM participant, it trumps all levels of the Quality Payment Program. So, any designation beyond the qualifying APM would not matter because the QP has the highest level of participation because we capture your advanced APM participation and you have exceeded the threshold.

So, what am I saying? The five percent bonus will go to that TIN where you did the work and then any other work will come through the entities where that participant worked. But we only make that designation with the group that we calculated.

Jennifer Montgomery: Okay. So, if I'm understanding you correctly, you're saying that if the provider does work through the other TIN besides where he's QP, they get whatever the bonus might be for that – so MIPS APM, for instance, or MIPS?

Dr. Corey Henderson: No. So, under the advance APM, they only receive the five percent bonus for that entity that receives that qualifying APM participant. If they are in other models, then they don't have to do the additional duplicative work or work that may be required because we do give them the qualifying APM status.

Outside of that the other models that we're looking at, specifically they would have their own requirements, but they do not receive the five percent bonus. It's only the clinician and the entity that they're working in that received the five percent bonus through that TIN. It's not the five percent bonus follows the clinician, it is actually a TIN level designation.

Jennifer Montgomery: Okay. All right. Thank you.

Nicole Cooney: Thank you very much.

Operator: Your next question comes from the line of Donna Kale.

Donna Kale: Hi there. I'm calling from Partners in the Nephrology and Endocrinology in Pittsburgh, Pennsylvania. And we have a question about the scoring sheets that CMS puts out for the E/M visits. We get internal audits and we wondered if they were going to be updated. And if so when to consider the new documentation requirements?

Ann Marshall: Hi, this is Ann Marshall. I'm not sure what you mean by scoring sheets.

Donna Kale: Hello.

Nicole Cooney: I – we can still hear you.

Ann Marshall: Hello?

Donna Kale: Hello. Hello. This is Donna Kale. I didn't hear your question.

Nicole Cooney: Go ahead, Ann.

Ann Marshall: Hi. We – I'm not sure what you mean by scoring sheets. Is this may be something that comes from your MAC rather than from CMS proper?

Donna Kale: Well, I called my MAC about it and they told me – I had to escalate it up to the supervisory level – and they told me that the score sheets came directly to them from cms.gov and the AMA and they had an interactive tool called an E/M calculator. And they denied that they designed it. They said it came directly from CMS. So, if I got incorrect information, I apologize.

Hello?

Nicole Cooney: Give us one second.

Donna Kale: Thank you.

Nicole Cooney: If you could send that in to us, the resource box that I gave before was M-L-N as in Medicare Learning Network, MLN events, plural with an S team@cms.hhs.gov. That's MLNeventsteam@cms.hhs.gov.

Donna Kale: Okay.

Nicole Cooney: We're going to try to connect with the right people, Okay? Thank you.

Donna Kale: Okay. I'll get the reference number from my MAC. Thank you.

Nicole Cooney: Okay, thank you.

Operator: Your next question comes from a line of Kara Tucars.

Kara Tucars: Hi. Thank you. This is Kara Tucars from Select Medical Outpatient and I'm looking for clarification mostly for the quality measures, as far as for PT and OT.

There were – in the rule, it was decided that they would not combine falls plan of care and assessments 154 and 155. They were going to leave them separate.

However, when you look at the PT and OT sheet that includes which measures to report on, if not using photo, there's only four measures and not the two plan of care or fall risk measures included.

And so, I was wondering if you had any clarification for that as well as several – there's a little bit of confusion as to whether we report on 60 percent of all Medicare patients or all patients. And if it's all patients, are we to submit the data to CMS through the registry on all of our patients or just 60 percent of our Medicare patients?

Adam Richards: So. Okay, so for the first question, I would have to double check in on that. But I – we – I think with the upcoming release of the quality measures that should answer those questions on to what are – onto which measures that are available for PTs and OTs.

Your second question on data completeness and you said you are reporting through a registry, correct?

Kara Tucars: Correct. Yes, not an individual to claim form, a qualified registry.

Adam Richards: Okay. Yes.

Nicole Cooney: Okay. Can you send that to us at MLNeventsteam@cms.hhs.gov. We want to follow up with you on that.

Kara Tucars: Okay. Yes, I can do that. And if I …

Nicole Cooney: Thank you very …

Kara Tucars: … one more quick one. Okay. Group opt-ins, you had mentioned that you were looking for feedback on the opt-in policy. Would that include the group opt-in and should I include that in my MLN question?

Adam Richards: Yes. So we are looking …

Kara Tucars: to MLN question.

Adam Richards: Sure, yes. Absolutely. Anything – any feedback that you have on how we can operationalize our opt-in policy, we encourage you to send that to us.

However, let me give you a separate email because that's where all of our user research is going just so we know that we get it we can start acting on it.

So that email address is – just got to pull it up real quick. It is CMSQPPfeedback@Ketchum K-E-T-C-H-U-M dot com, and just let us know that you're interested in providing feedback on opt-in and we'll get you – we'll get you set up.

Kara Tucars: Okay, great. Thank you so much.

Adam Richards: Yes.

Nicole Cooney: Thank you. Dorothy, I have time for one final question.

Operator: Your final question comes from the line of Farheim Narval.

Farheim Narval: Hi. This is Farheim, Thanks for taking my call. I have one simple question.

The E/M codes that we are supposed to submit do they still remain 99212 to 215? And does that start in 2019 or does it start in 2021?

Emily Yoder: Hi. This is Emily Yoder. So, any changes to the coding and payment for E/M office outpatients, starts in CY 2021.

As our finalized policy – as part of that, we are maintaining the CPT code numbers for those services. We're just paying a single rate for the levels 2 through 4.

Farheim Naval: But what is the point in submitting separate codes from 212 to 214, if you're going to get paid the same amount? I mean, how does that benefit in our submission of those codes?

Emily Yoder: That's a really good question. I think from our perspective, we wanted to make this as – to avoid administrative burden as much as possible. And creating G-codes would require many more sorts of systems changes, whereas right now, you guys are still billing those codes. And so there would be continuity across the billing.

We also note that we are continuing to solicit feedback and work with stakeholders. And so, the codes that might be for 2021 may not be the same codes that we have now.

Fahreim Naval: All right. Thank you so much.

Additional Information

Nicole Cooney: Thank you. Just a few closing remarks. The audio recording and written transcripts of today's call will be available in about 10 business days on our call web page. We'll also announce our availability in the MLN Connects newsletter.

All registrants today will receive an E-mail to evaluate our call, and we hope that you pick a few minutes to tell us about your experience. Again, my name is Nicole Cooney and I would like to thank our administrator, our presenters and also thank you for participating in today's Medicare Learning Network call on the Physician Fee Schedule Final Rule.

Have a great day, everyone.

Operator: Thank you for participating in today's conference call. You may now disconnect.