A Few Things to Note On the Physician Fee Schedule, Hospital OPPS, and ASC Final Rules

Always an anticipated announcement, in early November, The Centers for Medicare & Medicaid Services (CMS) released the Calendar Year (CY) 2020 Physician Fee Schedule[i] and the Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System[ii] Final Rules. The below summarizes a few of the provisions and forthcoming changes from the Final Rules impacting our space as behavioral health providers:

Opioid Treatment and Telehealth

CMS finalized a bundled payment for the management and treatment of opioid use disorders (HCPCS codes G2086, G2087, G2088). The monthly payment covers care coordination, individual and group therapy, and counseling for opioids. The codes which will be added to the Medicare approved telehealth list will allow for the patient's home to be the originating site and services will not be limited for these codes solely to rural areas. Typically telehealth codes contain restrictions on the originating site and geographical location to qualify for Medicare reimbursement. However, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act which became effective in July of 2019, statutorily removed geographic limitations for telehealth services furnished to individuals diagnosed with a substance use disorder (SUD) for the purpose of treating the SUD or a co-occurring mental health disorder. The change allows telehealth services for treatment of a diagnosed SUD or co-occurring mental health disorder to be furnished to individuals at any telehealth originating site (other than a renal dialysis facility). However, no originating site facility fee is permitted when the individual's home is the originating site. The new opioid use disorder codes, G2086 – G2088 will become effective on the telehealth list on January 1, 2020.

Hospital Price Transparency[iii]

Price transparency for health care services has been an increased point of discussion following the January 2019 requirement that hospitals post their price lists online in an effort to empower consumers to make informed decisions about their care. The Final Rule continues in that effort by requiring hospitals to disclose the rates they negotiate with insurers beginning in 2021 (or as stated by CMS, they are "finalizing that these policies would be effective January 1, 2021"). This includes a requirement that hospitals post their "standard charges" which is defined by CMS as including, gross charges, discounted cash prices, payer-specific negotiated charges, de-identified minimum negotiated charges, and de-identified maximum negotiated charges. Hospitals will be required to disclose the standard charge for all items and services, including supplies, facility fees and professional charges for employed physicians and other practitioners. Another requirement laid out under the Final Rule is that hospitals will have to publicize the payer-specific negotiated rates online in a searchable and consumer-friendly manner for 300 services that patients are likely to shop around for when searching for health care services. Of the 300 "shoppable" services, 70 of the services are stipulated in the Final Rule and hospitals can choose the other 230 services to post online.

Supervision for Therapeutic Outpatient Hospital or CAH Services and Supplies

Another highly anticipated change was in regards to the supervision levels as specified at 42 C.F.R. § 410.27(a)(1)(iv)(B) (*Therapeutic outpatient hospital or CAH services and supplies incident to a physician's or nonphysician practitioner's service*). While the Final Rule makes a change toward general supervision as the default or minimum level of supervision for therapeutic outpatient services, CMS specified that they may choose to require direct or even personal supervision for particular services (which is consistent in their current application of the regulation that calls for different levels of supervision throughout section 410.27 of the CFR). CMS also remains consistent in their current application of direct supervision for certain services such as nonsurgical extended duration therapeutic services and pulmonary and cardiac rehabilitation services (supervision for pulmonary and cardiac rehabilitation services must be by a doctor of medicine or osteopathy, 42 C.F.R. § 410.27(a)(1)(iv)(D), while Medicare outpatient hospital therapeutic services generally may be supervised by a physician or certain non-physician practitioners).

As stated by CMS in the final rule, many outpatient therapeutic services involve a level of complexity and risk such that direct supervision would be warranted even though only general supervision is required. Therefore, it is also important to remember that the requirement for general supervision for outpatient therapeutic services does not preclude hospitals from requiring a higher level of supervision for outpatient therapeutic services either when the physician administering the medical procedure decides that it is appropriate to do so or as may be required by clinical policies, credentialing procedures or hospital bylaws.

Physician Supervision Requirements for Physician Assistants

In the Final Rule, effective January 1, 2020, CMS updated its regulation on physician supervision of physician assistants (PAs) to give PAs greater flexibility to practice more broadly in the current health care system by deferring to state law and state scope of practice. In the absence of any state rules, CMS will be finalizing a revision to the current supervision requirement to clarify that physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services. Such physician supervision is evidenced by documenting the PA's scope of practice and indicating the working relationship(s) the PA has with the supervising physician(s) when furnishing professional services.

According to the American Academy of PAs news release[iv] about the Final Rule, the change is in line with what has occurred in recent years, including several states replacing the term "supervision" with other terms such as collaboration to better reflect current PA practice and some states authorizing the PA's employer and/or employing facility to determine how PAs, physicians, and other members of the healthcare team interact clinically.

Review and Verification of Medical Record Documentation

In an effort to reduce documentation burdens on providers, CMS finalized broad modifications to the documentation policy so that physicians, physician assistants, and advanced practice registered nurses (APRNs – nurse practitioners, clinical nurse specialists, certified nurse-midwives and certified registered nurse anesthetists) can review and verify (sign and date), rather than re-documenting, notes made in the medical record by other physicians, residents, medical, physician assistant, and APRN students, nurses, or other members of the medical team. CMS also clarified who qualifies as students, listing medical students and PAs, nurse practitioners, clinical nurse specialists, certified nurse midwives and certified registered nurse anesthetist students.

Evaluation and Management (E/M) Office Visit Codes

In the Final Rule, CMS introduced changes to the E/M Office Visit codes aimed at reducing the administrative burden on providers. The new codes which go into effect on *January 1, 2021* will, among other things, streamline the documentation requirements by requiring performance of history and exam only as medically appropriate; providing physicians greater choice in determining code levels for office visits by simplifying the selection between Medical Decision Making (MDM) and Total Time; ensure payer consistency by modifying the criteria for MDM adding and clarifying key definitions; filling coding gaps by creating a shorter prolonged services code to account for extended physician time taking care of patients; and, and deleting CPT code 99201 thereby reducing the number of levels from five to four for office/outpatient E/M visits for new patients.

E/M Office Visit codes account for a large percentage of healthcare billable services and have not seen a change in several years which makes means these changes will be far reaching in the health care community. For additional information on the E/M changes, the American Medical Association has developed an educational website[v] dedicated solely to the E/M changes as well as free online training[vi].

2-Midnight Rule Exemption

In the Final Rule, CMS will establish a two-year exemption from Beneficiary and Family-Centered Care Quality Improvement Organizations (BFCC-QIOs) referrals to Recovery Audit Contractors (RACs) and RAC reviews for patient status (site-of-service) for procedures that are removed from the Inpatient Only (IPO) list under the OPPS beginning on January 1, 2020. Under the new policy, BFCC-QIO's reviews of short-stay inpatient claims for procedures that have been removed from the IPO list within the first two years will be for medical necessity of the underlying services and to educate providers and practitioners regarding compliance with the 2-midnight rule, but claims will not be denied solely based on patient status/site of service alone.

CMS stated that the two-year exemption period would allow providers time to update their billing systems and gain experience with respect to newly removed procedures eligible to be paid under either the Inpatient Prospective Payment System (IPPS) or OPPS, while avoiding potential adverse site of service determinations.

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[i] https://www.federalregister.gov/documents/2019/11/15/2019-24086/medicare-program-cy-2020-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other

[ii] https://www.federalregister.gov/documents/2019/11/12/2019-24138/medicare-program-changes-to-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center

[iii] CMS Hospital Price Transparency Requirements Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/cy-2020-hospital-outpatient-prospective-payment-system-opps-policy-changes-hospital-price

[iv] https://www.aapa.org/news-central/2019/11/medicare-will-defer-to-state-law-requirements-on-how-pas-work-with-physicians/

[v] https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management?utm_source=Selligent&utm_medium=email&utm_term=%25m%25d%25y&utm_content=HS_PD_CPT_AssistantNewsletter_111119&utm_campaign=HS_PD_CPT_AssistantNewsletter_FINAL&utm_uid=11944508&utm_effort=&utm_h=

[vi] https://edhub.ama-assn.org/module/2736085?resultClick=1&bypassSolrId=J_2736085&utm_source=Selligent&utm_medium=email&utm_term=%25m%25d%25y&utm_content=HS_PD_CPT_AssistantNewsletter_111119&utm_campaign=HS_PD_CPT_AssistantNewsletter_FINAL&utm_uid=11944508&utm_effort=&utm_h=