NAMDRC

WASHINGTON WATCHLINE

PHYSICIAN ADVOCACY FOR EXCELLENCE IN THE DELIVERY OF PULMONARY, CRITICAL CARE AND SLEEP MEDICINE

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Medicare's Evolving Payment Policy for Outpatient Care

In addition to the proposed changes to the Merit-based Incentive Payment System (MIPS), discussed in last month's *Washington Watchline*, the Centers for Medicare & Medicaid Services (CMS) has proposed significant upgrades to compensation for outpatient evaluation and management (E&M) services. These upgrades include an increase in the work RVUs for the outpatient CPT codes, a new set of Medicare-developed HCPCS G codes for Chronic Care Management (CCM) services, the development of new billing codes for Chronic Care Remote Physiologic Monitoring Services, new coding for Principal Care Management (PCM) services and an increase in compensation for Transitional Care Management Services. The new framework and values will be effective January 2021 and, if finalized, the changes have the potential to significantly increase pulmonary office income.

Revision of the Outpatient CPT Codes

The proposal by CMS to revise the documentation and compensation for outpatient services in the 2019 Physicians Fee Schedule final rule (with comment period) engendered vigorous debate and strongly worded comments. In response to the comments, the Agency delayed the implementation of the compensation framework. In January and February of this year, CMS hosted a series of listening sessions on the proposed changes for outpatient payment while, coincidently, the American Medical Association (AMA) CPT Editorial Panel was developing their own set of recommendations. After brief consideration, CMS staff decided to align Medicare's outpatient E&M coding with the AMA recommendations.

The revised coding framework, now proposed by CMS in the recent notice, reduces the number of service levels to 4 for new patients but retains the 5 levels of coding and reimbursement for established patients. In a major step, CMS will abandon the detailed medical record documentation required to justify the choice of a code level. Instead, the code level reported would be

The ***WASHINGTON WATCHLINE*** *is published monthly and provides timely information to NAMDRC members on pending legislative and regulatory issues that impact directly on the practice of pulmonary medicine.*

NAMDRC's primary mission is to improve access to quality care for patients with respiratory disease by removing regulatory and legislative barriers to appropriate treatment.

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NAMDRC 43rd Annual Meeting and Educational Conference will be held:
March 12– 14, 2020
The Scottsdale Resort at McCormick Ranch
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"NAMDRC will directly affect your practice more than any other organization to which you belong."

based on either the level of medical decision making or the total time personally spent by the reporting practitioner on the day of the visit, including face-to-face and non-face-to-face time.

New Patient Codes

CPT code 99202; work RVU of 0.93. (Current 0.93). When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.

CPT code 99203; work RVU of 1.6 (Current 1.42). When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.

CPT code 99204; work RVU of 2.6 (Current 2.43). When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.

CPT code 99205; work RVU of 3.5 (Current 3.17). When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.

Prolonged Services add on 99XXX; work RVU of 0.61 For services 75 minutes or longer for the new patient, total time with or without direct patient contact, on the date of the primary service each 15 minutes. This code is added on to 99205.

Established Patient Codes

CPT code 99211; work RVU of 0.18 (Current 0.18). This code is retained for use by office staff for the management of an established patient, that may not require the presence of a physician or other qualified health care professional.

CPT code 99212; work RVU of 0.7 (Current 0.48). When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.

CPT code 99213; work RVU of 1.3 (Current 0.97). When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.

CPT code 99214; work RVU of 1.92 (Current 1.5). When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.

CPT code 99215; work RVU of 2.8 (current 2.11). When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

Prolonged Services add on 99XXX; work RVU of 0.61, for services 55 minutes or longer for the established patient, with or without direct patient contact, on the date of the primary service each 15 minutes. The code is added on to 99215.

Add on Code GPC1X

While accepting the increased work RVUs, recommended by the AMA, CMS believes this does not adequately compensate physicians for the extended work that is occasionally required for continuous patient care and certain types of specialist visits. CMS proposes to combine two pre-existing codes,GPC1X and GCG0X, into one code for a complex visit inherent to evaluation and management related to a patient's single, serious, or complex chronic condition.

GPC1X, can be added on to any of the base office codes. GPC1X has been assigned a work RVU of 0.33 and a physician time of 11 minutes. The proposed Physicians Fee Schedule seems to imply that this code covers non-face-to-face time but does not indicate whether this is a one time code or may be used for every subsequent 11 minutes.

Chronic Care Management Services

CMS has previously recognized the work performed by clinical office staff by establishing billing codes to cover their non-face-to-face care management services. After reviewing their data, the Agency believes that these services are either under utilized or under billed. The Agency proposes to adopt two new G codes, with new increments of clinical staff time to replace the existing single CPT code 99490 for non-complex services. These codes apply to patients with at least two chronic conditions expected to last at least 12 months, or until the death of the patient.

GCCC1 a work RVU of 0.61. This base code is for the initial 20 minutes of clinical staff time, directed by a physician or other qualified health care professional, per calendar month.

GCCC2 a work RVU of 0.54. This add on code is for each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

For complex chronic care management services CMS has proposed to adopt two new G codes that would be used for billing instead of CPT codes 99487 and 99489:

GCCC3, work RVU of 1.00. Complex chronic care management services including a comprehensive care plan with moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month.

GCCC4, a work RVU of 0.50, each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month.

Principal Care Management Services

CMS is proposing to create new coding for Principal Care Management (PCM) services, which would pay clinicians for providing care management for patients with a single, chronic, serious and high risk condition and includes non-face-to-face care. CMS expects that most of these services would be billed by specialists. In most instances, initiation of PCM would be triggered by an exacerbation of the patient's illness or recent hospitalization such that disease-specific care management is warranted. It is expected that the specialist would need to provide a disease-specific care plan or need to make frequent adjustments to the patient's medication regimen. The primary care practitioner would still oversee the overall care for the patient while the practitioner billing for PCM services would provide care management services for the specific illness. CMS is proposing to make separate payment for PCM services via two new G codes in 2020.

GPPP1, work RVU of 1.28. This code applies to physician or other qualified health care professional for a single high-risk disease, at least 30 minutes of time per calendar month with the following elements: *One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.*

GPPP2, work RVU of 0.61. This code applies to clinical staff time for care management for a single high-risk disease services, at least 30 minutes of time directed by a physician or other qualified health care professional, per calendar month with the same elements as GPPP1.

Transitional Care Management Services

After surveying their data CMS believes these codes are under used and has proposed to increase the work RVU of the codes.

CPT code 99495 work RVU increase from 2.11 to 2.36. Transitional care management requiring medical decision making of at least moderate complexity and a face-to-face visit within 14 calendar days of discharge.

CPT code 99496 RVU increase from3.05 to 3.10. Transitional care management requiring medical decision making of at least high complexity with a face-to-face visit within 7 calendar days of discharge.

Medicare Payment for Telecommunications Services

For the last several years, both the AMA and CMS have been taking steps to reimburse providers for implementation of telecommunications services. CPT and HCPCS codes have been developed and assigned payment values for both telemedicine and remote physiologic monitoring services. In the CY 2019 PFS Final Rule, CMS finalized separate payment for a number of services that could be furnished via telecommunications technology. It is the position of CMS that these services will expand access to care and create more opportunities for patients to access more personalized care management, as well as connect with their physicians more quickly. CMS has also stated that the goal is to mitigate the need for unnecessary office visits to specialists. Accordingly, in the proposed 2020 PFS, CMS includes several proposals for updating Medicare physician payment for non-face - to face, communication technology-based services.

The following codes are for: *Assessment and management services conducted through telephone, internet, or electronic health record consultations furnished when a patient's treating physician or other qualified healthcare professional requests the opinion of a consulting physician or qualified healthcare professional, with specific specialty expertise, to assist with the diagnosis and management of a patient's problem without the need for the patient's face-to-face contact with the consulting physician.*

CPT codes 99446 - 99449. Work RVU's range from 0.35 to 1.4 for *inter-professional telephone/ Internet/electronic health record assessment and management service provided by a consultative physician, including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional.*

CPT code 99451 Work RVU 0.7 *for inter-professional telephone/Internet/electronic health record assessment and management service* ***provided by a consultative physician****, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.*

CPT code 99452 Work RVU 0.7 for inter-professional telephone/Internet/electronic health record referral service **provided by a treating/requesting physician** or other qualified health care professional.

Over the last several years the Commission has recommended that Congress add legislation that would provide bonus payments to physicians billing evaluation and management codes (E&M) and accepting responsibility for continuous patient care. Sadly, these recommendations have been ignored by legislators. In last year's report, to address several years of passive devaluation of ambulatory E&M services, they rec-

Chronic Care Remote Physiologic Monitoring

CMS has established reimbursement codes for Chronic Care Remote Physiologic Monitoring. In the 2020 PFS the Agency proposes to modify some existing codes as well as add several codes for compensation. Chronic Care Remote Physiologic Monitoring services involve the collection, analysis, and interpretation of digitally collected physiologic data, followed by the development of a treatment plan, and the managing of a patient under the treatment plan. CMS has made it clear that these codes do not fall under statutory restrictions placed on telemedicine since there is no face-to-face, or screen-to-screen, encounter.

CPT Code 99453, total RVUs 0.54 Remote monitoring of physiologic parameters which may include weight, blood pressure, pulse oximetry, respiratory flow rate, etc. This code covers the initial set-up and patient education on use of equipment.

CPT Code 99454 total RVUs 1.78. This code covers the remote monitoring of physiologic parameters with daily recordings and transmission every 30 days.

CPT Code 99457: work RVUs 0.61. *For remote physiologic monitoring and treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.*

In September 2018, the CPT Editorial Panel revised the CPT code structure for CPT code 99457 effective beginning in CY 2020. The new code structure retains CPT code 99457 as a base code that describes the first 20 minutes of the treatment management services. CMS proposes to adopt an add on code, **CPT code 994X0**, with a work RVU of 0.50, to describe subsequent 20 minute intervals of the service.

CPT Codes 9X0X1, 9X0X2, and 9X0X3

These non-face-to face codes to describe patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office.

CPT code 9X0X1 work RVUs of 0.25. *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes.*

CPT code 9X0X2 work RVU 0.50. *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes.*

CPT code 9X0X3 work RVU 0.80. *Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes.*

A Significant Shift in the CMS Policy

The last several years have seen a significant shift in CMS policy as manifest in the changes to the reimbursement framework. A decade ago CMS paid only for services that were reasonable, necessary and face-to-face. While the retraction of the requirement for extensive and repetitive documentation to justify billing for outpatient services and the shift to time spent, including non face-to-face time, or complexity of medical decision making as criteria for selecting the code level is welcome. The willingness to establish codes and compensate for telecommunication services is also a welcome policy. However, with the proliferation of these codes, there seems to be significant overlap of the descriptors and requirements. Hopefully, when the proposed rule is finalized, CMS will address this situation. It does appear that CMS intends many of these codes to be used by qualified office staff in non face to face situations. Notably, the work RVUs for several of the codes are quite low with prolonged periods of service and would be useful only for practices with large populations of chronically ill or for home care companies. Furthermore, some may experience discomfort rendering advice to the primary care physician without evaluating the patient in person. An informed history and careful physical exam by a physician with extensive experience, in a specific discipline, often has great value in alleviating a patients medical problems and reducing the cost of care.

PRODUCT AND TECHNOLOGY NEWS!

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NAMDRC Membership Benefits AT *A GLANCE...*

- Monthly publication of the Washington Watchline, providing timely information for practicing physicians;
- Publication of Current Controversies focusing on one specific Pulmonary/Critical Care Issue in each publication;
- Regulatory updates;
- Discounted Annual Meeting registration fees;
- The Executive Office Staff as a resource on a wide range of clinical and management issues; and
- The knowledge that NAMDRC is an advocate for you and your profession.

https://www.namdrc.org/content/issue-advocacy

One of NAMDRC's primary reasons for existence is to provide both clinicians and patients with the most up-to-date information regarding pulmonary medicine. Bookmark this page!

The complexity of our nation's health care system in general, and Medicare in particular, create a true challenge for physicians and their office staffs. One of NAMDRC's key strengths is to offer assistance on a myriad of coding, coverage and payment issues.

In fact, NAMDRC members indicate that their #1 reason for belonging to and continuing membership in the Association is its voice before regulatory agencies and legislators. That effective voice is translated into providing members with timely information, identifying important Federal Register announcements, pertinent statements and notices by the Centers for Medicare and Medicaid Services, the Durable Medical Equipment Regional Carriers, and local medical review policies.

ABOUT NAMDRC:

Established over three decades ago, the National Association for Medical Direction of Respiratory Care (NAMDRC) is a national organization of physicians whose mission is to educate its members and address regulatory, legislative and payment issues that relate to the delivery of healthcare to patients with respiratory disorders.

NAMDRC members, all physicians, work in close to 2,000 hospitals nationwide, primarily in respiratory care departments and critical/intensive care units. They also have responsibilities for sleep labs, management of blood gas laboratories, pulmonary rehabilitation services, and other respiratory related services.

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MEMBERSHIP OPPORTUNITIES WITH NAMDRC

INSTITUTIONAL MEMBERSHIPS

NAMDRC has restructured its membership opportunities to more accurately reflect how physicians practice medicine, acknowledging that genuine "private practice" is nowhere near as prevalent today as it was even five years ago. Physicians are now employees of hospitals and medical systems.

To improve our communication with you and hospital based colleagues, we have revamped our dues structure, with individual/small practice remaining basically the same as it is today. We are renaming our group practice options into two specific categories:

Institutional Membership/Gold for institutions that identify at least seven physicians, but no more than 20 physicians as members of NAMDRC. Every identified physician will receive our monthly newsletter, the **Washington Watchline,** and the institution will receive two half price registrations for our Annual Conference at the standard member rate.

Institutional Membership/Platinum for institutions that identify at least 21, but no more than 50 physicians as members of NAMDRC. Every identified physician will receive our monthly newsletter, the **Washington Watchline,** and the institution will receive four half price registrations for our Annual Conference at the standard member rate.

Small Group Practice (1-6 physicians)	$295 for renewal
	$395 for new member (includes one-time $100 initiation fee.)
Gold Institutional Membership (7-20 physicians)	$1750
Platinum Institutional Membership (21 – 50 physicians)	$2500

If you are based at a particular institution, we believe this is an excellent way to bring NAMDRC and its benefits to the attention of many of your colleagues. And the aggregate cost, per membership, drops dramatically under these new membership categories.

RENEW NOW!

JOIN NOW!

Go to www.namdrc.org and join and/or renew your membership online.

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NAMDRC INSTITUTIONAL MEMBERSHIP APPLICATION

Please select the category you are applying for:

☐ Small Group Practice (1-6 physicians)	$295/year for renewal
☐ NEW Small Group Practice (1-6 Physicians) *(includes one-time $100 initiation fee)*	$395 for new member/year
☐ Gold Institutional Membership (7-20 physicians) *Includes two half price registrations for NAMDRC Annual Conference at the standard member rate.*	$1750/year
☐ Platinum Institutional Membership (21-50 physicians) *Includes two half price registrations for NAMDRC* Annual Conference at the standard member rate.	$2500/year

INSTITUTIONAL MEMBERSHIP INFORMATION

Institutional Name: _____

Contact Person:_____

Email address: _____

Address: _____

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City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

PAYMENT INFORMATION *(Make check payable to "NAMDRC")*

❒ American Express ❒ MasterCard ❒ Visa

Credit Card Number_____ Expiration Date _____CCV_____

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USE THE ATTACHED MEMBERSHIP FORM TO LIST ALL MEMBERS OF YOUR GROUP

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NAMDRC INSTITUTIONAL MEMBERSHIP FORM

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