

Jurisdiction 5 Medical Societies

What's New for 2019?

Information on the changes to the Medicare Program for 2019

2019 Deductible, Coinsurance, and Premiums

- Medicare Learning Network Matters Number [MM11025](#) - Updates to Medicare Deductible, Coinsurance and Premium Rates for 2019
- Standard Part B premium
 - \$135.50
 - Standard for 2018 was \$134
 - Premiums can be higher based on penalty or income amounts
- Standard Part A premium
 - Beneficiaries with more than 40 quarters of reported work do not have a premium
 - Base premium is \$437
 - Can increase based on penalties
- Part B deductible
 - \$185 for 2019
 - Was \$183 for 2018
- Part B coinsurance
 - 20% of the allowed amount for most services
 - Some services have no coinsurance or deductible
 - There is a 25% coinsurance for colorectal cancer screening performed in the outpatient departments of non-outpatient prospective payment system (non-OPPS) hospitals and ambulatory surgical centers (ASC)
 - MLN Matters Number [MM5387](#) - Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change
- Part A deductible
 - Deductible is due for each episode of payment
 - An episode begins when there has been no incurred Part A expenses for a period of 60 days or more
 - \$1364 for 2019
 - Was \$1340 for 2018

Medicare Physician Fee Schedule Relative Value File (MPFSRVF)

- Published/maintained by CMS
 - Sometimes called CMS Relative Value File, or the [Database](#)
 - Use Unzip software to view the files
 - The MPFSRVF appears as an Excel file; a key to the various payment indicators is available as a downloadable (Adobe Acrobat Document) file
 - Searchable [Medicare Physician Fee Schedule Look-up Tool](#)
 - [How to Use the Searchable Medicare Physician Fee Schedule](#)
- Updated quarterly
 - Majority of changes made at the beginning of the calendar year (CY)
- Includes
 - Deleted codes
 - New codes
 - Changes in status or other identifying factors
 - Payment indicators

Therapy threshold amounts - MM11055 - Annual Update to the Per-Beneficiary Therapy Amounts

- Providers will no longer need to report the functional status
- Providers will no longer need to report the severity modifiers
- There are no therapy caps, but instead amounts that apply to “KX Modifier Thresholds”
 - Physical therapy and speech language pathology - \$2,040
 - Occupational therapy - \$2,040
- Services provided above these amounts must meet medical necessity
 - Add KX modifier as appropriate
 - Services without the KX modifier, above the threshold amounts, are denied
- Targeted medical review amounts are lower for 2019 at \$3,000 for physical therapy and speech language pathology and \$3,000 for occupational therapy

Functional Status and Severity Modifiers

- Removing the requirement for functional limitation G-codes
 - Codes G8978 through G8999
 - Codes G9158 through G9186
- Codes are still valid until December 31, 2019
 - If submitted, codes will not cause a rejection

- Codes will not be used for Medicare processing
- Documentation requirements as described in the CMS Internet-Only Manual (IOM) Publication 100-02, Benefit Policy Manual, [Chapter 15](#), Section 220.3 still apply
- Severity Modifier
 - Modifiers CH through CN
 - We anticipate Medicare will accept them, but not use for processing

Therapy Assistants

- Physical therapy and occupational therapy assistants
 - 2019 – Voluntary use of modifiers to indicate therapy service provided “in whole or in part” by a therapy assistant
 - Modifier CQ – Services provided by a physical therapy assistant (PTA) in whole or in part
 - Modifier CO – Services provided by an occupational therapy assistant (OTA) in whole or in part
 - CMS is also finalizing a de minimis standard under which a service is furnished in whole or in part by a PTA or OTA when more than 10 percent of the service is furnished by the PTA or OTA, instead of the proposed definition that applied when a PTA or OTA furnished any minute of a therapeutic service
 - Administrative tasks are not considered therapy services and not separately payable

Patient Relationship Modifiers

- Modifiers
 - X1 – Continuous, broad service
 - For reporting services by clinicians who provide the principal care for a patient, with no planned endpoint of the relationship. Services in this category represent comprehensive care, dealing with the entire scope of patient problems, either directly or in a care coordination role.
 - X2 – Continuous, focused service
 - For reporting services by clinicians whose expertise is needed for the ongoing management of a chronic disease or a condition that needs to be managed and followed for a long time.
 - X3 – Episodic, broad service
 - For reporting services by clinicians who have broad responsibility for the comprehensive needs of the patients, that is limited to a defined period and circumstance, such as a hospitalization.
 - X4 – Episodic, focused service
 - For reporting services by specialty focused clinicians who provide time-limited care. The patient has a problem, acute or chronic, that will be treated with surgery, radiation, or some other type of generally time-limited intervention.

- X5 – Only as ordered by another clinician
 - For reporting services by a clinician who furnishes care to the patient only as ordered by another clinician. This patient relationship category is reported for patient relationships that may not be adequately captured in the previous four categories.
- The use of these modifiers is voluntary for services January 1, 2018 and after for those providers eligible for the Quality Payment Program (QPP) and Medicare Incentive Payment System (MIPS)
 - Other practitioners may also submit
- CMS may use these modifiers to adjust payments, either through the fee-for-service or QPP/MIPS, in the future
- CMS has a presentation on this from a [webinar](#) provided in October 2018

Evaluation and Management (E/M)

- E/M services account for approximately 40% of allowed charges under the Physician Fee Schedule
- Office or other outpatient services account for approximately 20% of allowed charges
- There are three ways of documentation to choose a level of service
 - The 1995 Documentation Guidelines
 - The 1997 Documentation Guidelines
 - Time
 - More than 50% of the face-to-face time (office) or floor or unit time (inpatient) is spent in counseling and/or coordination of care
 - Documentation would show the total time of the visit, the time spent in counseling and/or coordination of care, and the nature of that counseling and/or coordination
 - This time is spent with the practitioner
- CMS did not eliminate the “per diem” payment on E/M when multiple services are provided on the same date, by the same person, or members of the same group with the same specialty
 - The exceptions are in the CMS IOM, Publication 100-04, [Chapter 12](#), Section 30.6.7.B
- Elements in medical record for new and established office or other outpatient visits
 - Providers will no longer be required to re-enter information in the patient’s medical record
 - Provider will be required to review what they believe is clinically appropriate
 - Identify any new, changed, updated, information
 - Notate the review in the medical record
- CMS is not implementing the primary and specialty care add-on codes

Teaching Physicians

- The teaching physician presence for E/M services and procedures may be documented by the teaching physician, the resident, or the nurse

Home Visits (Codes 99341 – 99350)

- Services require the medical record to show the medical necessity of seeing the patient
- The final rule indicates that for services after January 1, 2019, there would not be a separate medical necessity requirement for seeing the patient in the home instead of the office or clinic setting
 - CMS has not changed the IOM, Publication 100-04, Claims Processing Manual, [Chapter 12](#), Section 30.6.14.1 as of the date of completion of this document

Communication Technology – Physician

- Virtual check-in - G2012
- This is talking to the physician – not the nursing or clinical staff – this can also be the Non-Physician Practitioner (NPP) when the NPP is billing
- This is not subject to any geographic locations restrictions
- This service would not be related to a previous E/M service within 7 days or within 24 hours or the next available appointment following the service
- The patient has to give verbal consent as they have cost sharing responsibilities
- Reminder – provider cannot waive cost sharing across the board
- Purpose is the determination of whether the patient needs a visit or not
- There are no frequency limitations
- There is no requirement for the technology used, however, this is real-time synchronous audio/video interaction between the physician/NPP and the patient

Remote Pre-recorded Evaluations

- New service G2010
- Not subject to geographic locations
- Not within 7 days of previous related E/M service or within 24 hours or the next available appointment of E/M
- Physician or NPP looking at pictures, video, etc. of what patient has taken and making medical decision
 - This can't be ancillary staff – must be the physician or NPP
- The physician or NPP would be following up with the patient within 24 hours

- This would include documentation of the viewing of the information and a follow up with the patient on any findings and communication
- The follow up can be e-mail, telephone, text, etc.
- Must meet Health Insurance Portability and Accountability Act (HIPAA) guidelines,
- If video or photos not clear, the practitioner must contact the patient

Interprofessional Internet Consultation

- This is conversation or interaction between the patient's physician and a consulting physician
- These are time-based codes
- There are two sets of codes
 - One for the primary care (or the person requesting the consult)
 - 99452
 - One for the consultant (the person providing the consultation)
 - 99446 – 99449, 99451
 - Patient has to provide verbal permission as recorded in the treating (requesting) provider's medical records
 - Patient has cost sharing
 - Documentation
 - Treating physician – medical record necessitating the need for the consult and the consultation report
 - Consulting physician – medical record showing the medical necessity, the request, and the consultation report
 - There are no geographic restrictions

Chronic Care Remote Physiological Monitoring

- Payment will now be allowed for code 99453, 99454, 99457
 - 99453 – patient set up and instruction
 - Professional time
 - Cannot be provided as an incident to service
 - 99454 – daily or programmed alerts
 - Billable every 30 days
 - 99457 – 20 minutes or more of clinical staff, MD/DO or NPP time during the month
- Will require beneficiary consent
- Beneficiary will have cost sharing

Telehealth

- New services added
 - G0513 and G0514 – These are prolonged preventive care services
 - Billable with appropriate preventive service available by telehealth
 - List of [telehealth](#) services can be found on the CMS website
- Home dialysis clinical assessments
 - Face-to-face
 - One visit per month for the first three months of home dialysis
 - One visit every three consecutive months thereafter
 - Removing the rural site requirement, but only for the purposes of the monthly ESRD-related clinical assessments
 - The patient home can be an originating site
 - No originating site fee could be submitted
 - A renal dialysis facility can be an originating site
 - The renal facility can submit an originating site fee
- Patients with an acute stroke MLN [MM10883](#) – New Modifier for Expanding the Use of Telehealth for Individuals with Stroke
- Removes the rural restriction
- Applies to the current list of originating sites
 - These sites can submit an originating site fee
- Adds a mobile stroke unit
 - Definition – a mobile unit that furnishes services to diagnose, evaluate, and/or treat symptoms of an acute stroke
 - The mobile unit may not submit an originating site fee
 - Both the originating and distant site practitioner will add modifier G0 (zero) to the procedure code

Payment Differential – Clinic Visit Services in Provider-Based Departments

- Implemented as a method to control unnecessary increases in utilization of outpatient services
- A two year phase-in beginning in 2019, applies a Physician Fee Schedule-equivalent payment rate for the clinic visit services when provided at an off-campus provider-based department that is paid under the Outpatient Prospective Payment System (OPPS)
 - Reduction is in the hospital payment
- Beneficiary has cost sharing for both the physician charges and the hospital charge

Ambulatory Surgical Centers (ASC)

- CMS is finalizing policies to
 - Increase the number of services that can be furnished in ASCs
 - Ensure that ASC payment for procedures involving certain high-cost devices generally parallels the payment amount provided to hospital outpatient departments for these devices
 - Help ensure that ASCs remain competitive by addressing the differential between how ASC payment rates and hospital outpatient department payment rates are updated for inflation

New Physician Specialty Code for Undersea and Hyperbaric Medicine

- [MM10666](#) - New Physician Specialty Code for Undersea and Hyperbaric Medicine; effective January 1, 2019; implemented January 7, 2019
 - MACs will recognize Undersea and Hyperbaric Medicine (D4) as a valid specialty type for the following edits
 - Ordering/Referring
 - Critical Access Hospital (CAH) Method II attending and rendering
 - Attending, operating, or other physician or non-physician practitioner listed on a CAH claim
- CMS-855I and CMS-855O paper applications will be updated to reflect the new physician specialty in the future
 - In the interim, new providers shall select the 'Undefined physician type' option on the enrollment application and specify Undersea and Hyperbaric Medicine in the space provided
 - Existing enrolled providers who want to update their specialty to reflect the new specialty must submit a change of information application to their MAC

Change to Local Coverage Determination (LCD) Process

- [MM10901](#) - Local Coverage Determinations, effective October 3, 2019; implemented January 7, 2019
 - 2016 21st Century Cures Act included changes to the LCD process, adding language to 1862(l)(5)(D) of the Social Security Act (the Act) to describe the LCD process
 - CMS manual format revamped so the local coverage process is easy to understand
 - Stakeholders can effectively engage in the process
 - Nine key parts to New LCD Process
 - Transparency also carries through to the reconsideration process
 - Requirements included in the manual language
 - Other important changes
 - MACs shall finalize or retire all proposed LCDs within one calendar year of publication date on the Medicare Coverage Database (MCD)

- All codes will be removed from LCDs and placed in billing & coding articles that are linked to the LCD

Other Reminders – Recurring Calendar Year Changes

- 2019 Pricing is available on the WPS GHA Portal
 - Navigate to Fee Schedules and Reimbursement Topic Center>>Guides and Resources>>2019 Medicare Physician Fee Schedules (MPFS) or 2019 Specialty Pricing
 - Refer to 2019 Specialty Pricing for 2019 Average Sales Price (ASP) Drug Pricing Files
 - ASP pricing for Part B drugs may increase or decrease from year to year
- Skilled Nursing Facility (SNF) Consolidated Billing (CB)
 - Links to 2019 Part A/Part B MAC Update are available on the CMS [SNF Consolidated Billing web page](#) on the CMS website
- Update to National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) edits are described in [MM11044](#) - Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.0, Effective January 1, 2019

Appropriate Use Criteria (AUC)

- Program to increase the rate of appropriate advanced diagnostic imaging services provided to Medicare beneficiaries
- CMS has information in [MM10481](#)
- Examples of advanced imaging services include
 - Computerized tomography
 - Positron emission tomography
 - Nuclear medicine
 - Magnetic resonance imaging
- Physician treating the patient and ordering the service is required to consult a qualified Clinical Decision Support Mechanism (CDSM) at the time of the order
- The CDSM will provide one of three responses
 - Adheres
 - Does not adhere
 - No AUC applicable
- Service is an applicable service, provided in an applicable setting, and paid under an applicable payment system
 - Services are listed in MM10481

- Applicable setting includes
 - Physician office
 - Hospital outpatient department
 - Ambulatory surgical centers (ASC)
 - Independent diagnostic testing facilities (IDTF)
 - Provider-led outpatient setting
- Applicable payment systems include
 - Physician fee schedule
 - Outpatient Prospective Payment System (OPPS)
 - ASC
- Reporting is currently voluntary
- Ordering practitioner will provide the information to the furnishing practitioner
- There are three exceptions
 - Ordering physician is having a significant hardship
 - Patient has an emergency medical condition
 - Patient is an inpatient and payment is made under Part A
- Significant hardship is defined as
 - Insufficient internet access
 - Electronic health record or CDSM vendor issues
 - Extreme and uncontrollable circumstances
- Furnishing practitioner will append modifier QQ to the claim line
 - Modifier QQ (Ordering professional consulted a qualified CDSM for this service and the related data was provided to the furnishing physician)
 - Furnishing physician is aware of the result of the ordering physician's consultation with the CDSM
 - Report on the same claim line as the advanced diagnostic imaging service
 - Report on both the facility and professional claim
- Clinical staff, under the incident to provisions, may consult the CDSM

Hyperlinks

Document	Hyperlink
MM11025 – Update to Medicare Deductible, Coinsurance, and Premium Rates for 2019	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM11025.pdf
MM5387 – Colorectal Cancer Screening Flexible Sigmoidoscopy and Colonoscopy Coinsurance Payment Change	https://www.cms.gov/outreach-and-education/medicare-mln/mlnmattersarticles/downloads/MM5387.pdf
Medicare Physician Fee Schedule Relative Value File	https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Relative-Value-Files.html
Medicare Physician Fee Schedule Look Up Tool	https://www.cms.gov/apps/physician-fee-schedule/search/search-criteria.aspx
How to Use the Searchable Medicare Physician Fee Schedule	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/How to MPFS Booklet ICN901344.pdf
MM11055 - Annual Update to the Per-Beneficiary Therapy Amounts	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11055.pdf
CMS IOM Publication 100-02, Benefit Policy Manual, Chapter 15	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/bp102c15.pdf
CMS Webcast on Patient Relationship Code	https://www.cms.gov/Outreach-and-Education/Outreach/NPC/National-Provider-Calls-and-Events-Items/2018-10-17-MACRA.html
CMS IOM Publication 100-04, Claims Processing, Chapter 12	https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf
List of Telehealth Services	https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.html

MM10883 - New Modifier for Expanding the Use of Telehealth for Individuals with Stroke	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10883.pdf
MM1066 - New Physician Specialty Code for Undersea and Hyperbaric Medicine	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10666.pdf
MM10901 - Local Coverage Determinations	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/MM10901.pdf
SNF Consolidated Billing	https://www.cms.gov/Medicare/Billing/SNFConsolidatedBilling/index.html
MM11044 - Quarterly Update to the National Correct Coding Initiative (NCCI) Procedure-to-Procedure (PTP) Edits, Version 25.0, Effective January 1, 2019	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11044.pdf
MM10481 – Appropriate Use Criteria for Advanced Diagnostic Imaging – Voluntary Participation and Reporting Period – Claims Processing Requirements – Modifier QQ	https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM10481.pdf

Resources

Acronyms	Definition
ASC	Ambulatory Surgical Center
ASP	Average Sales Price
AUC	Appropriate Use Criteria
CAH	Critical Access Hospital
CB	Consolidated Billing
CDSM	Clinical Decision Support Mechanisms
CMS	Centers for Medicare & Medicaid Services
CR	Change Request
E/M	Evaluation and Management
HIPAA	Health Insurance Portability & Accountability Act
IDTF	Independent Diagnostic Testing Facilities

IOM	Internet-Only Manual
LCD	Local Coverage Determination
MAC	Medicare Administrative Contractor
MCD	Medicare Coverage Database
MIPS	Medicare Incentive Payment System
MM	Medicare Learning Network Matters
MPFSRVF	Medicare Physician Fee Schedule Relative Value File
NPP	Non-Physician Practitioner
OPPS	Outpatient Prospective Payment System
OTA	Occupational Therapy Assistant
OTP	Opioid Treatment Program
PTA	Physical Therapy Assistant
QPP	Quality Payment Program
SNF	Skilled Nursing Facility
SUPPORT	Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment