Providing Services for Janssen, the Pharmaceutical Companies of Johnson & Johnson cp-69097v1 12/18

Calendar Year 2019 Medicare Physician Fee Schedule Final Rule (Non-Quality Payment Program)

December 2018

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Overview

- The Centers for Medicare and Medicaid Services (CMS) published the calendar year (CY) 2019 Medicare Physician Fee Schedule Final Rule on November 23, 2018

CMS, Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program—Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions From the Medicare Shared Savings Program—Accountable Care Organizations—Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder Under the Substance Use-Disorder Prevention That Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act Proposed Rule, 83 Fed. Reg. 59,452 (November 23, 2018).

Key issues addressed in the Final Rule

Single/blended payment rate for certain evaluation and management (E/M) office visits, among numerous other changes to be phased in related to E/M services

Reduction to Wholesale Acquisition Cost (WAC) add-on from 6% to 3% for new drugs and biologics

Expanded access to virtual care

PFS conversion factor update

Documentation of E/M services requires choosing the appropriate code

- Currently, documentation requirements differ for each level
- Clinicians rely on the 1995 and 1997 E/M documentation guidelines
- Billing for an E/M visit requires the selection of a CPT code that best reflects:
  - Patient type (new vs. established);
  - Setting of service (e.g., outpatient or inpatient); and
  - Level of E/M service performed

83 Fed. Reg. at 59,629, 59,633, 59,638.

CMS will phase in policies related to E/M services over the next several years

Effective CY 2019

- Practitioners will continue to use the 1995 or 1997 versions of the E/M guidelines they use today
- Policies adopted to reduce duplicative documentation

Effective CY 2021

- Single/blended rate for visit levels 2 through 4
- Other policies adopted to reduce administrative burden and improve payment accuracy

83 Fed. Reg. at 59,629, 59,630, 59,633, 59,638.

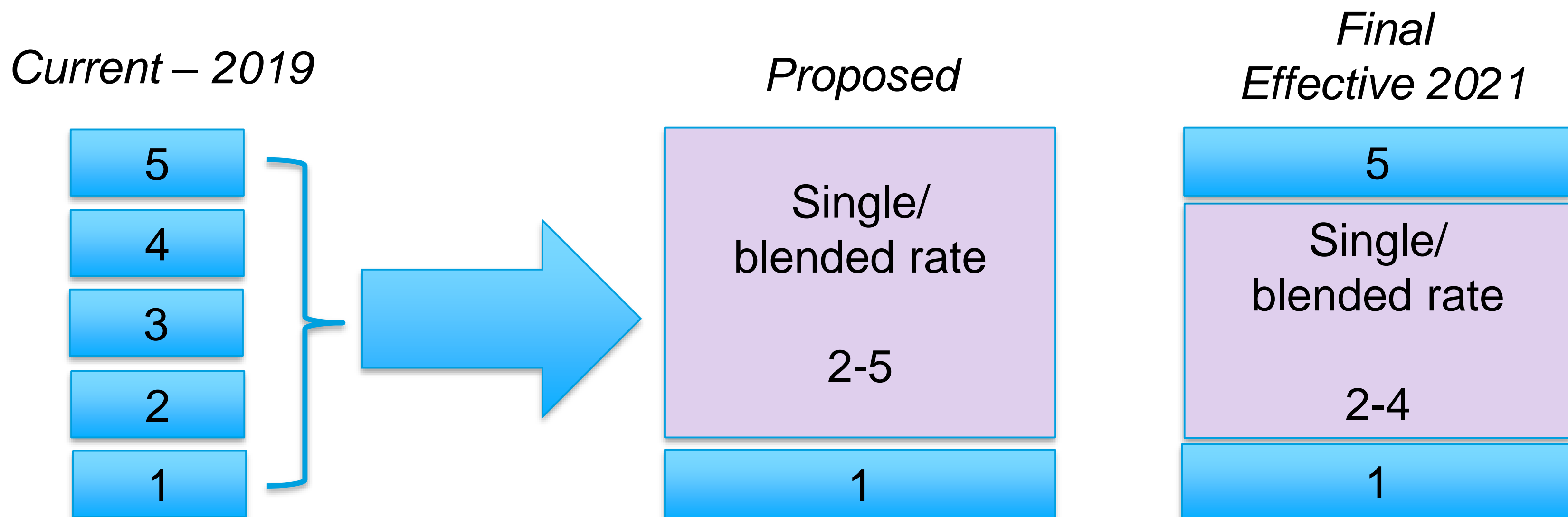
CMS will start by implementing changes to streamline documentation in CY 2019

- CMS finalized the following policies for **CY 2019** related to E/M services:
  - Practitioners only need to document what has changed from a prior visit or critical items that have not changed, rather than re-documenting information
  - Practitioners do not need to re-enter information that has already been entered by ancillary staff, the beneficiary, or residents
  - No need to document the medical necessity of a home visit instead of an office visit

83 Fed. Reg. at 59,630.

CMS will establish a single/blended rate for levels 2 through 4 E/M office visits effective CY 2021

- There are currently 5 distinct code levels, with payment increasing for each level
- CMS will establish a **single/blended payment** for levels 2 through 4 E/M office visits



- This policy does not affect drug administration codes

83 Fed. Reg. at 59,629, 59,638.

CMS will establish a single/blended rate for levels 2 through 4 E/M office visits effective CY 2021, cont'd

- There will be one blended rate for established patients and a separate blended rate for new patients

Final Rule Table 24B: Comparison of CY 2018 and CY 2021 Estimated Nat'l Payment Amts.

	Complexity Level under CPT	CY 2018 Visit Code Alone Est. Nat'l Payment Amt.	CY 2021 Visit Code Alone Est. Nat'l Payment Amt.	CY 2021 Visit Code with Either Primary or Specialized Care Add-On Code*	CY 2021 Visit Code with New Extended Services Code
New Patient	Level 2	$76	$130	$143	$197
	Level 3	$110			
	Level 4	$167			
	Level 5	$211	$212		
Established Patient	Level 2	$45	$90	$103	$157
	Level 3	$74			
	Level 4	$109			
	Level 5	$148	$149		

**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.*

83 Fed. Reg. at 59,629, 59,638, 59,649 tbl. 24B.

CMS will streamline coding for the E/M single/blended rate

- CMS will retain the current CPT coding structure for E/M visits
- CMS also will create HCPCS G-code add-ons to recognize additional resource costs for:
    - Primary care visits;
    - Non-procedural specialty care (available to any specialty); and
    - Extended visits
- CMS will not finalize its proposal to implement a multiple procedure payment adjustment that would have reduced payment when an E/M visit is furnished with a procedure on the same day

83 Fed. Reg. at 59,640, 59,644.

CMS will implement additional policies to reduce administrative burden related to E/M services, beginning in 2021

- Option to document office/outpatient E/M visits using medical decision-making (MDM) **OR** time **OR** the current 1995 **OR** 1997 E/M documentation guidelines

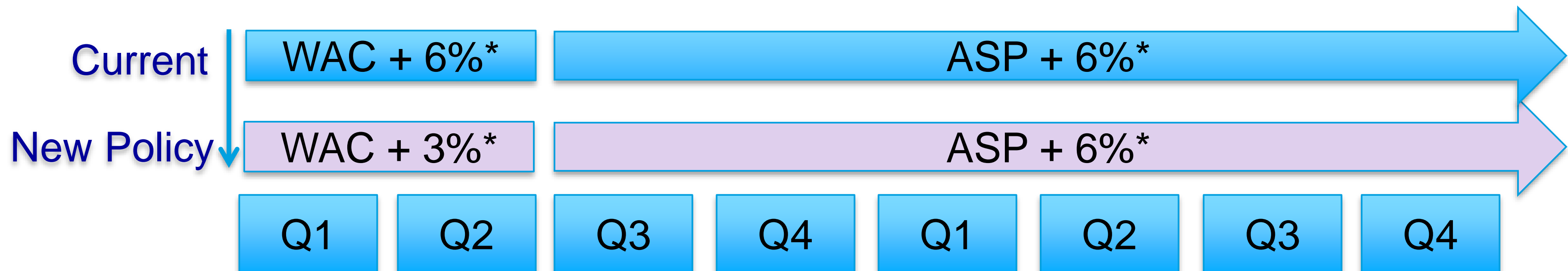
- Use time as the governing factor in selecting visit level and documenting E/M visits, regardless of whether counseling or care coordination dominate the visit

- Use documentation standards currently required for level 2 E/M visits for levels 2 through 4 E/M visits

83 Fed. Reg. at 59,629, 59,633, 59,638.

Final Rule reduces WAC-based payment add-on from 6% to 3% for NEW drugs and biologics

- WAC-based payment is only used for new drugs and biologics for which Average Sales Price (ASP) is not available
    - When a drug first launches, ASP may not be available for one to three quarters to allow time for manufacturers to report sales data and for CMS to calculate ASP



* Subject to sequestration

83 Fed. Reg. at 59,666.

Reduction in WAC-based payment add-on from 6% to 3% for NEW drugs and biologics, cont'd

- Due to the relatively brief timeframe when the reduction will be in place, the policy is unlikely to have a significant impact on Medicare drug spending overall
  - But will affect newly launched drugs and biologics
- This reduction will **not** affect ASP-based payment for established Part B drugs

83 Fed. Reg. at 59,666.

Reimbursement for drugs set at default rate of ASP + 6%

- Drugs and biologicals will continue to be reimbursed at the statutory default rate of **ASP + 6%**
    - With sequestration still in effect, this amount is effectively ASP + 4.3%
- No changes to PFS payment methodology for biosimilar biologics

83 Fed. Reg. at 59,666; 2 U.S.C. § 901a(6)(B).

Final Rule aims to expand access to virtual care

Non- “Telehealth”

Payment will not be subject to limitations on Medicare telehealth services (e.g., beneficiary located in a rural area)

- Virtual check-ins (i.e., brief, non-face-to-face assessments);
- Evaluation of patient-submitted images or videos (e.g., “store and forward”);
- Inter-professional internet consultation;
- Chronic care remote physiologic monitoring; and
- Communication technology-based services furnished by Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

“Telehealth”

- Prolonged preventive services (beyond the typical service time of the primary procedures)

83 Fed. Reg. at 59,483-84, 59,492, 59,494; 42 U.S.C § 1395m(m).

PFS conversion factor will be $36.04 in CY 2019

- CMS slightly increases the conversion factor from **$35.99 to $36.04**
- Update reflects:
  - +.25% increase required under the Medicare Access and CHIP Reauthorization Act (MACRA) and amended by the Bipartisan Budget Act of 2018 (BBA); and
  - -.12% budget neutrality adjustment

83 Fed. Reg. at 60,027.