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CMS Proposals: Say Bye to Direct Supervision, Hello to Separate E/M Payments, Prior Auth

By Nina Youngstrom

In a stunning reversal, CMS plans to drop the direct physician supervision requirement for outpatient therapeutic services performed at hospitals and critical access hospitals and instead require general supervision — and do the same for some other services, including remote patient monitoring, according to the proposed 2020 Outpatient Prospective Payment System (OPPS) and Medicare Physician Fee Schedule (MPFS) regulations announced July 29. That's not the only turnabout in the regulations: CMS said it won't move forward with plans to pay one rate for three levels of evaluation and management (E/M) services, while keeping a promise to relax documentation requirements. The regulations also would bring prior authorization to a handful of procedures and more site neutrality, as CMS approves total knee replacement in ambulatory surgery centers. And hospitals are faced with an expansion of price transparency requirements that attorneys are dubious about (see story, below).

The relaxation of physician supervision requirements, which appears in different forms in both regulations, came out of left field. "What I thought was really unexpected and a good thing that CMS did is the change to supervision of hospital outpatient and critical access hospital services," says Valerie Rinkle, president of Valorize Consulting. "It's a little bit of back to the future with a cherry on top." Before 2010, CMS assumed that as long as physicians were around the hospitals, they provided for the safety of patients. But partly fueled by concerns about lack of oversight in off-campus provider-based departments, CMS created a stricter standard with direct supervision, she says, although critical access hospitals (CAHs) were repeatedly given a pass. Now it proposes to drop direct supervision, and apply general supervision to all outpatient therapeutic hospital services, whether provided at CAHs or on or off campus.

The relaxation of supervision requirements should put an end to overpayment refunds and False Claims Act cases based on the failure of physicians to directly supervise. But Rinkle worries about a possible ulterior motive. Will CMS use the relaxed physician supervision level to "continue the march toward site neutrality for certain services?" Her reasoning: Hospitals have pointed to direct supervision as a driver of higher costs in outpatient departments compared to freestanding clinics.

There was also good news for providers on E/M services and documentation. CMS proposed to drop its plan to pay physicians the same amount for CPT code levels two, three and four for office/outpatient visits, which was announced in the 2019 MPFS, although delayed until 2021 ("CMS Finalizes M.D. Payment Changes, With Delay And Level Five; Documentation Is Eased," *RMC* 27, no. 39). CMS would continue to pay separately for all E/M levels of service, which also would have different values to better capture their work relative value units (RVUs). CMS is proposing to adopt work RVUs for office/outpatient E/M codes and the new prolonged services add-on code recommended by the RVS Update Committee of the American Medical Association (see box). CMS also plans to ditch the lowest level CPT code, 99201, for new patients.

'This Is Big for Doctors'

Physicians will still have more flexibility in the way they document to support their levels of service. In addition

to the 1995 and 1997 Medicare documentation guidelines, physicians have the option of documenting their E/M level of service according to the medical decision making (without exam and history) or the time spent with the patient. CMS added to the documentation menu in 2019, but the changes don't take effect until 2021.

"Almost every proposal talks about reducing the burden on providers," says attorney Richelle Marting, with the Forbes Law Group in Overland Park, Kansas. Allowing time to drive the level of service "is great for everybody. It's very simple." Physicians won't have to spend more than 50% of their time counseling patients or coordinating their care when they choose time to select the level of service. "This is big for doctors," says Ronald Hirsch, M.D., vice president of R1 RCM, who spoke about the proposed regulations at the National Physician Advisor and Utilization Review Boot Camp in Washington, D.C., on July 29. "The total time they spend includes all the time they spend during the day preparing for the visit, during the visit and after the visit. If doctors review 600 pages of medical records before the encounter and make calls, they can count it all."

Other documentation requirements are relaxed in the 2020 proposed MPFS regulation. Physicians wouldn't have to document services that are already documented by members of the medical team. "We propose to establish a general principle to allow the physician, the PA, or the APRN who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students or other members of the medical team," CMS said.

Physicians would be good to go as long as they review and sign the documentation. "You can see this as a progression" from a corner turned by CMS in February 2018, when it announced that all medical-student documentation counts for E/M billing, says attorney Ed Gaines, an executive with Zotec Partners in Greensboro, North Carolina. As a result of that change, unveiled in Medicare Transmittal 3971, teaching hospitals can charge Medicare for E/M services performed by teaching physicians when medical students document the exam, medical decision making and other parts of the patient encounter ("In Surprise Move, CMS OKs Medical Student Documentation for E/M Billing," *RMC* 27, no. 6).

Now, in the 2020 proposed MPFS, CMS is swinging open the same door wider, Gaines says. It follows because "hospital-based clinicians practice now in teams," he says. From a clinical perspective, it doesn't make sense for the physician to document again what was already documented by a member of the same care team, as long as the physician takes responsibility for reviewing and verifying the history, physical and medical decision making, Gaines says. This will be particularly helpful for rural hospitals, which may be largely staffed by advanced practice providers and under a lot of financial strain, especially in states that haven't expanded Medicaid, Gaines says.

Why Not 100% Prepay Review vs. Prior Auth?

For the first time, CMS plans to move into prior authorization for medical services. It already exists for repetitive ambulance services and durable medical equipment (and CMS experimented with prior auth for hyperbaric oxygen). The OPPS regulation proposes a prior authorization process for blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty and vein ablation "as a method for controlling unnecessary increases" in their volume. While program integrity controls are appropriate, CMS could do 100% prepayment review instead, Rinkle says. The problem with prior authorization is that providers could get the green light upfront and still be denied after the fact because Medicare won't be reviewing the documentation from the procedure that is ultimately performed. "Here is my concern: Medicare starts to build the infrastructure for prior authorization and it's the frog in the boiling pot. It's…expanded to more and more services," Rinkle says. That wouldn't be welcome, because prior authorization can delay care, which may increase the costs and make it harder for patients to recuperate, she explains. However, CMS said if providers are approved for 90% of procedures over 180 days, they will be free of prior authorization.

More Site Neutrality to Come

CMS is determined to avoid paying more for services when they're performed in a hospital vs. other sites, and continues to revise policies to further that goal. The move to so-called site neutrality would take another step in 2020 with a proposal to allow total knee replacements (TKRs) to be performed in ambulatory surgery centers (ASCs). This comes merely a year after CMS took TKRs off the inpatient-only (IPO) list. "This is huge," Hirsch says. If physicians own all or part of the ASC, they may shift patients there.

CMS is considering only allowing ASCs that already perform TKRs on commercial patients to operate on Medicare patients. "CMS is aware that Medicare patients are not clinically the same as people with commercial insurance," Hirsch says. "They're interested in watching to make sure there are no patient safety issues."

CMS also proposed to cover cardiac stent placement performed in ASCs, which "blew my mind," Hirsch says. In 2019, CMS started paying for 12 cardiac catheterization procedures in ASCs, but left out stents, "and they can't have data on outcomes for safety yet. It seems like a very big leap done very quickly."

Meanwhile, total hip replacement is being pushed off the IPO list, which subjects them to the two-midnight rule, assuming the provision is finalized. CMS, however, said Medicare administrative contractors reviewing any procedures removed from the IPO list under Targeted Probe and Educate (TPE) would not recoup money for medically unnecessary admissions or refer hospitals to recovery audit contractors for the first year, although the educate part of TPE will continue. This audit reprieve is being applied for the first time to total hip arthroplasty, Hirsch says.

Also on site neutrality, CMS will complete its phase-in of reduced payments for clinic visits to excepted off-campus provider-based departments. In 2019, Medicare cut payments by 30%, and starting in 2020, the cuts double to 60% ("OPPS Rule: Site-Neutral Payments, 340B Cuts May Make Provider-Based Space Less Winning," *RMC* 27, no. 40).

Remote Patient Monitoring Gets Its Mojo Back

The proposed MPFS would change the physician supervision requirement from direct to general for various services. That's make or break for a new benefit, remote patient monitoring (RPM).

In the 2019 MPFS, CMS added three codes for RPM, which allows providers to receive patient data, such as blood pressure, glucose levels and heart rate, which can be transmitted using software applications on the patient's smartphone, tablet or other device. Marting says RPM is useful for taking care of patients between visits and could prevent unnecessary in-person visits and hospitalizations, especially in rural areas. Originally, CMS didn't allow incident-to billing with RPM, but fixed that in a March 15 correction to the MPFS ("CMS OKs Incident-To Billing for Remote Monitoring, But Glass is Half Empty," *RMC* 28, no. 11), because clinical staff is in the best position to manage the data and alert the physician when patients need to come in, she explains. But incident-to billing only got providers halfway there because it requires direct physician supervision, and they were less likely to use RPM because of the expense that entailed.

That problem would disappear, however, under the proposed 2020 MPFS regulation, which allows RPM to be provided under general supervision. "Practices can get together and share a clinical staff person, and the clinical staff person doesn't have to be physically on site," Marting says. "Ultimately, it's better quality of care."

She said CMS also put remote patient monitoring in the context of care management for patients with chronic conditions, which undergo revisions and expansion in the proposed MPFS regulation. "We believe gaps remain in coding and payment, such as for care management of patients having a single, serious, or complex chronic

condition," CMS said. It would create new coding for "principal care management," which allows providers to receive Medicare payment for managing only one chronic condition. However, Marting cautions, the definition of chronic conditions for principal care management is different than the definition under chronic care management.

Because of low utilization of transitional care management (TCM) services, CMS is proposing to remove billing restrictions that may hinder their use. TCM services were introduced in 2013 to encourage primary care physicians to arrange a visit with patients almost immediately after their discharge from the hospital with an eye toward improving quality of care. But there are restrictions. Marting says 57 HCPCS codes can't be billed at the same time that TCM codes are billed. CMS wants to fix that by removing 14 codes from the list. But it wants feedback first. And again, the physician supervision requirements for various care management services would be changed from direct to general.

CMS also would allow physician assistants (PAs) to perform services incident to the physician's services with general supervision instead of direct supervision, as long as it's within their scope of practice under state law. "It means the physician doesn't have to be on site where the PA is practicing, but has to be generally available and responsible for services, depending on what state you are in," Marting says.

Ignoring the 340B Reckoning?

As if a federal court hadn't invalidated its payment cuts to the 340B drug program, CMS again includes them in the 2020 OPPS proposed rule. In 2018, CMS reduced the amount that's paid for 340B drugs from average sales price (ASP) plus 6% to ASP minus 22.5%, and now says, "We are proposing to continue to pay ASP -22.5 percent for 340B-acquired drugs including when furnished in nonexcepted off-campus [provider-based departments] paid under the PFS."

It's unclear if this will materialize next year, and hospitals may get the money back retroactively. In response to a lawsuit filed against CMS by the American Hospital Association and other hospital trade groups, the U.S. District Court for the District of Columbia threw out the 340B payment cuts in December 2018 and again this year. Judge Rudolph Contreras kicked it back to the parties to figure out how to provide relief to the hospitals without wreaking havoc on the OPPS. However, on July 10, the judge granted a motion that essentially clears a path for HHS to appeal his rulings to the U.S. Court of Appeals for the D.C. Circuit.

For now, CMS is acting as if it hasn't lost in court, says attorney Andy Ruskin, with Morgan Lewis in Washington, D.C. "They didn't make a single change to existing policy. It is a policy at the same time as it is litigation posturing," he notes. CMS is "disregarding an order of the court, although it is on appeal. Everything about its current stand says it is business as usual."

CMS also asked for comment on whether, if it's forced to abandon the payment cut, "a rate of ASP+3 percent could be an appropriate remedial payment amount for these drugs, both for CY 2020 and for purposes of determining the remedy for CYs 2018 and 2019." That would still be above the actual cost hospitals incur for the drugs, CMS maintains, "and it is being proposed solely because of the court decision." Another idea floated is only paying the hospitals affected by the 340B cuts.

Ruskin says CMS is "alluding to the fact CMS may make payments to affected hospitals, on the one hand, but then simply take back that same sum of money in future years from all hospitals by reducing the update factor" to make up for the reversal of the cuts because payment regulations have to be budget neutral, and the 340B provision is not.

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morganlewis.com, Hirsch at rhirsch@r1rcm.com and Rinkle at valerie.rinkle@valorizeconsulting.com. View the proposed MPFS at http://bit.ly/2OrXDIY and the proposed OPPS at http://bit.ly/2LOC5ns.

Proposed Regulation: How Revalued Codes Would Affect Payment

In the proposed 2020 Medicare Physician Fee Schedule regulation, CMS incorporates the revalued payments adopted by the American Medical Association's CPT Editorial Panel. The table shows the percent increase in office visit work relative value units between 2019 and the proposed 2021 values, says attorney Richelle Marting, with the Forbes Law Group in Overland Park, Kansas, and shows a comparison of how national payment rates for those same codes are affected by the increases. Contact her at rmarting@forbeslawgroup.com.

Code	2019 work relative value units	2021 work relative value units	% Increase	Code	2019	2021
99202	0.93	0.93	-	99202	$77.48	$77.48
99203	1.42	1.6	12.5	99203	109.92	116.41
99204	2.43	2.6	7	99204	166.86	172.99
99205	3.17	3.5	10.41	99205	209.75	221.64
99212	0.48	0.7	45.83	99212	45.77	53.70
99213	0.97	1.3	34	99213	75.32	87.21
99214	1.50	1.92	28	99214	110.28	125.42
99215	2.11	2.8	32.7	99215	147.76	172.63