Posting of Standard Prices

Beginning January 1, 2019, hospitals must post their standard charges for all items and services in a machine readable format via the internet.

We have received several questions on the rule. An FAQ on the issue, posted by CMS, can be found here: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Downloads/FAQs-Req-Hospital-Public-List-Standard-Charges.pdf

This is not a new rule, as it originated from the Affordable Care Act. Prices are currently required to be available; the new *portion* of the rule is the detail they must be on the internet in a machine readable format, specifically a CSV or XML type file. PDF is not sufficient.

Critical access hospitals are included in this rule.

The rule covers any service or item your hospital provides, including those priced at zero. The purpose of this particular part is so if a patient is shopping between two hospitals, and one bills $10 for a Band-Aid but the next hospital includes it in its rates, the Band-Aid should show on both so the prices can be compared.

Since standard chargemasters are based on items descriptions and CPT codes as licensed by the America Medical Association (AMA), please ensure what you post complies with AMA's licensing requirements.

We also suggest having a contact number for someone to call to help them understand the chargemaster.

CMS currently does not have an enforcement method, but plans to have an enforcement and review process in place in the near future. We believe regardless of the enforcement of the program, hospitals should simply comply.

2019 Final OPPS Rule

CMS has expressed concern with the rate of increase in outpatient services, questioning whether the increases are sustainable or necessary. Section 1833(t)(2)(F) of the Social Security Act instructs CMS to "develop a method for controlling unnecessary increase in the volume of covered outpatient services." Their concerns not only include off-campus provider-based clinics, but also general increases in outpatient services.

Off-Campus Emergency Rooms

To track services provided in off-campus emergency rooms, CMS has proposed a new HCPCS modifier "-ER" to track services provided at these locations. This modifier would apply to all services provided at the off-campus emergency room, not just the emergency room visit. Reporting of the new modifier begins January 1, 2019.

Critical access hospitals are not required to report the modifier.

Grandfathered Off-Campus Locations

Site-Neutral Payments Extended to Grandfathered Locations – For years, we have discussed how CMS, MedPAC, the OIG, and Congress do not understand why they would pay a clinic more when provider-based to a hospital – particularly when the services "could be provided in a lower cost setting." They believe the reason hospitals purchase clinics is to take advantage of the higher payment rates.

Section 603 of the Budget Act of 2015 called for site-neutral payments to new provider-based off-campus locations of prospectively paid hospitals. In 2018 and 2019, these non-grandfathered locations are paid at 40 percent of the APC amount.

CMS invoked Section 1833(t)(2)(F) of the Social Security to further expand the use of "site-neutral payments," decreasing payments to all off-campus prospectively paid hospital based clinic payments billing HCPCS code G0463 (hospital outpatient clinic visit for assessment and management of a patient – this is the code that replaced CPT codes 99201 through 99205 and 99211 through 99215). This particular HCPCS code is the most frequently billed HCPCS code billed from off-campus provider-based locations.

The change is a two-year phase in. In 2019, these grandfathered locations will be paid 70 percent of the APC amount, but in 2020, they will be paid at the established site-neutral amount (currently at 40 percent, but subject to change if the non-grandfathered payment amount changes).

CMS estimates this change will save $380 million dollars a year, of which $80 million will be savings to the Medicare beneficiary.

Lower Payment for 340B Pass-Through Drugs Proposed – Further addressing growth of hospital-owned clinics, CMS finalized extending the decreased payment for pass-through drugs purchased under the 340B program to these non-grandfathered of-campus locations.

Expansion of Services Limitation Not Finalized – CMS had brought back its original proposal of limiting the expansion of services at grandfathered off-campus locations based on clinical families of services. Although they did not finalize limiting the expansion of services, they did say we may see future rule making. Limiting expansion of services would limit the amount of services provided that are not basic E/M codes (e.g. those still receiving 100 percent of the APC amount).

The off-campus items do not affect critical access hospitals.

Payment for 340B Drugs

Medicare pays a PPS hospital for pass-through drugs based average sales price (ASP), plus 6 percent. If no ASP is available, payment is wholesale acquisition cost (WAC), plus 6 percent; if neither ASP nor WAC are available, payment is 95 percent of the average wholesale price (AWP).

Starting January 1, 2019, payment for pass-through drugs lacking an ASP will be paid the WAC, plus 3 percent (down from 6 percent).

Remember, if these drugs are purchased with 340B discounts, payment is ASP minus 22.5 percent, WAC minus 22.5 percent, or 69.46 percent of the AWP, depending on the pricing available.

Changes to the Medicare Physician Fee Schedule Payment System

Office Visit Codes

Currently, physician clinics bill codes 99201 through 99205 and 99211 through 99215 for evaluation and management (E/M) of a patient. Medicare physician fee schedule pricing for these varies for each code.

Beginning January 1, 2021, Medicare will pay the level one and level five E/M codes at a base amount, with the remaining levels 2-4 at a combined amount. A clinic would still bill the appropriate E/M code, but payment amount would not vary between levels 2 through 4. If claiming a level 2-4, documentation would only need to meet the level 2 documentation requirements.

The proposed amounts for these combined codes were greater than the free-standing RHC rates currently in effect. CMS's response to this was that they do not have the authority to increase or change the method of payment to free-standing rural health clinics.

In our opinion, the only feasible way to continue as a free-standing rural health clinic in 2021 and future years is to have both a Medicaid rate and a utilization rate high enough to sustain the decrease in Medicare reimbursement.

Documentation Requirements

For calendar year 2019 and 2020, a physician should document the level of visit based on the 2015 or 2017 documentation guidelines (current documentation guidelines). For services beginning January 1, 2021, and after, E/M visits levels 2-5 documentation can be the current documentation guidelines, medical decision making (MDM), or time. For levels 2-4, documentation only needs to meet the level 2 documentation requirements, although you will bill with the appropriate CPT code (and new HCPCS code). Essentially, for level 2-4 visits you can use MDM or time, but for level 5 visits you need to meet the MDM (or current framework) definition to bill.

Merit-based Incentive Payment System (MIPS)

Added Eligible Clinicians – Medicare Access and CHIP Reauthorization Act (MACRA) requires a set group of practitioners to be part of the MIPS program if participating in Medicare. MACRA also allows CMS to expand the clinicians considered eligible clinicians, beginning with the 2021 payment year (2019 reporting year).

Beginning January 1, 2019, the following clinicians will be considered eligible clinicians for MIPS purposes:

- physical therapist
- occupational therapist
- speech therapist
- clinical psychologist
- audiologist
- registered dietician or nutrition professional

Although not part of the initial proposal, Speech therapists, audiologist and registered dieticians were included in the final definition. Clinical social workers, on the other hand, were initially proposed to become an eligible clinician, but ultimately removed from the list in the final rule.

Facility based clinicians above are not eligible for MIPS (e.g. hospital, CAH, or nursing home based clinicians).

Low-volume Criteria – Currently, eligible clinicians are automatically exempt from MIPS reporting if they meet any of the low-volume criteria. However, CMS believes eligible clinicians exist who would choose to report MIPS data (and therefore be subjected to MIPS adjustments), even if they meet the low-volume criteria. CMS added a third criterion to the existing low-volume criteria, allowing eligible clinicians who otherwise meet the low-volume criteria to opt in to MIPS. However, once an eligible clinician chooses to opt in for the year, they cannot change their minds at a later date. Low-volume criterion follows:

- 200 or fewer Medicare beneficiaries, OR
- $90,000 or less Medicare reimbursement, OR
- 200 or fewer covered professional services provided to Medicare beneficiaries (this is the new one)

Non Face-to-Face Physician Check-ins

CMS finalized two new HCPCS codes: G2012 – brief communication technology-based service to be paid for a practitioner discussing patient care over the phone, with the goal of determining whether a face-to-face E/M is necessary, and G2010 – remote evaluation of pre-recorded patient information "store and forward."

To bill, the following requirements must be met:

- the patient must be an established patient
- it cannot be related to any E/M services within the prior seven days
- if an E/M is indeed scheduled for the next day (or next available appointment), the amount cannot be charged
- the patient must provide consent for the services, as there will be patient cost sharing

These are services a RHC can provide. If a visit is deemed necessary, the cost of the call is included in the all-inclusive rate; if a visit is not necessary, CMS rules state the service can be billed separately beginning January 1, 2019.

In the case of G2012, the call must include 5-10 minutes of medical discussion and consent must be verbal.

In the case of G2010, follow up can be via the phone, email, secure text, audio video communication, or through a patient portal.

Telehealth and Opioid Abuse

CMS issued an interim final rule that for services on or after July 1, 2019, the originating site requirements of telehealth (where the patient can be located) are removed when treating individuals diagnosed with a substance use disorder or a co-occurring mental health disorder including the patient's home. The only location not approved as an originating site is a renal dialysis facility.

Because this is an interim final rule, comments can be made to CMS and revisions or clarification are forthcoming.

Closing

If you have any questions, please contact your DZA representative, or Shar Sheaffer at 509.242.0874.