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| **ISASS Comments on Independence Blue Cross Spinal Fusion Policy**  On August 25, 2020, ISASS sent a comment letter to Independent Blue Cross (IBC), the Blue Cross affiliate for the Greater Philadelphia area, regarding their recent Spinal Fusion Policy.  The IBC policy calls for attestation of failure of conservative treatment by a physiatrist. The letter from Dr. Frank Phillips, ISASS president, stated “ISASS believes that this intrusion has already been shown to create significant barriers to efficient care. ISASS questions the Level of Evidence supporting an additional consultation with a physiatrist to document that a patient has exhausted nonsurgical options. ISASS further maintains that the spine surgeon, rather than the physiatrist, is solely capable of the surgical decision making required to deliver spine surgery.”  ISASS will continue to follow the Spinal Fusion policy and seek opportunities to engage with IBC on this issue.  Read the IBC Spinal Fusion policy here: <https://medpolicy.ibx.com/ibc/Commercial/Pages/Policy/6C6218B5CEC0F18085258588005C4080.aspx>  Read the August 25th IBC letter here: [insert letter PDF here]  **CMS Issues Proposed Rule for 2021 Medicare Physician Fee Schedule: Specific Impact to Spine Procedures**  **PHYSICIAN PAYMENT PROVISIONS**  The 2021 Proposed Medicare Physician Fee Schedule Rule updated several policies and payment rates of relevance to ISASS members. Notably, budget neutrality adjustments have reduced the Conversion Factor associated with all CPT codes, from $36 per relative value unit (RVU) to $32 per RVU. This reduction, along with other code-specific adjustments, has impacted spine procedures by decreasing Medicare payments between 5% and 12%, compared with calendar year (CY) 2020 final rates.  Public comments are being accepted by Centers for Medicare & Medicaid Services (CMS) between now and 5pm Eastern on October 5. Comments may be submitted electronically via [this link](https://www.regulations.gov/comment?D=CMS-2020-0088-1604). ISASS encourages its members to express their interest in having these payment cuts reduced or reversed by the time of the rule’s effective date for procedures as of January 1, 2021. Comments do not need to be lengthy or formal; the more comments CMS receives from interested stakeholders, the more likely they are to make policy changes.  Among the most notable proposals, aside from the proposed draconian reductions, is a proposal to review the relative value for CPT code 22867, Coflex. Code 22867 was flagged in the proposed rule as potentially misvalued, and stakeholders are invited to provide comment and input on appropriate valuation for 22867, which was added to the Physician Fee Schedule in 2015 as a new Category I CPT code.  Access the [ISASS Spine Codes Comparison: 2020 vs. Proposed 2021](https://www.isass.org/wp-content/uploads/2020/08/Proposed-2021-PFS-Comparison-of-Spine-Codes.xlsx)  **Background**  Payment is made under the Physician Fee Schedule (PFS) for services furnished by physicians and other practitioners in all sites of service. These services include, but are not limited to, office visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services.  In addition to physicians, payment is made under the PFS to a variety of practitioners and entities, including nurse practitioners, physician assistants, and physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities.  Payments are based on the relative resources typically used to furnish the service. RVUs are applied to each service for physician work, practice expense, and malpractice. These RVUs become payment rates through the application of a conversion factor. Payment rates are calculated to include an overall payment update specified by statute.  In terms of surgical approach/access by anatomy in the spine, the following table of commonly reported spine procedure CPT codes describes how to consider applicable medical coding in CY 2021 relative to proposed payment cuts for 2021 procedures:  **CY 2021 PFS Proposed Rate-Setting and Conversion Factor**  In the proposed rule, CMS used a budget neutrality adjustment to account for changes in RVUs, as required by law, and updated the CY 2021 Proposed PFS conversion factor to $32.26 from $36.09—a dramatic decrease of $3.83 (-10.6%) compared with CY 2020 PFS conversion factor of $36.04. This conversion factor applies to all codes. For specific impact of this rule on spine codes, access the spine codes comparison spreadsheet.  **Evaluation and Management (EM) Services**  One bright spot in this Proposed Rule is the proposal by CMS to adopt changes developed by the American Medical Association for better accounting for Evaluation and Management (EM) services by dropping the current history and examination requirements, including dropping of the associated documentation requirements.  In lieu of significant history and examination, the physician can perform, and document, a medically appropriate history and/or examination.  Another key change is allowing physicians, based on their documentation, to select a code by time or medical decision making (MDM). There are major changes and revised terminology with MDM that provide much more clarification per the guidelines. For example, CPT 99213 would now have a low number/complexity of problem(s), medically appropriate history/examination, limited review of data, and low MDM or time (20-29 minutes). When choosing a code based on time, there is a minimum amount of time offered as guidance, which may not be the standard time for a given code’s level, but does represent the time the provider spends with the patient.  These new EM guidelines benefit primary care providers more than specialists. CMS has proposed a policy that they will give these providers an effective “raise” in the amount they are reimbursed for commonly undervalued EM services. While this is good for them, it is not good for specialists who perform specific services, such as surgeries and other interventions, and generally have a bundled payment. Bundled payments include initial EM service, the procedure, and any follow-up EM visits post-procedure. As a result of this proposed planned change, these providers will see a decrease in their payment due to the rule of budget neutrality. Budget neutrality basically says that there are X dollars in the pot, and where dollars are moved for higher payment, there must be a payment reduction in some other area of the pot—most often bundled services.  Congress can change this situation by passing new legislation, waiving budget neutrality, and making a more equal system of addressing the payment needs of EM services while not cutting payments from bundled procedural services, making a more equitable and fair payment system for all. We have seen Congress act in the past with previous [‘doc fix’ legislation](https://www.cbsnews.com/news/obama-signs-doc-fix-bill-changing-medicare-payments-to-doctors/#:~:text=The%20bill%2C%20known%20as%20the,repeatedly%20blocked%20the%20payment%20reductions.). While this latest “fix” is necessary to reverse the 10% cut to payments, the issue is more pervasive as costs of running clinical practices and facilities have increased as reimbursements have continuously decreased. Congress should address these latest cuts as well as the consistent reduction in reimbursement over the past 16 to 17 years.  Overall, while CMS proposed to reduce payment rates for spine procedures due to overarching laws requiring budget neutrality, physicians (and office staff) should be satisfied with the proposed EM changes for CY 2021. ISASS will continue to advocate for spine surgeons and the importance of appropriately reimbursing for medically necessary therapies and surgical procedures performed for Medicare patients.  ISASS will provide comments to CMS on the proposed rule by the October 5, 2020, deadline.  Read the CMS Fact Sheet on the Proposed PFS Rule [here.](https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-4) Read the Proposed PFS Rule [here.](https://www.federalregister.gov/documents/2020/08/17/2020-17127/medicare-program-cy-2021-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other)  **CMS Issues Proposed Rule for 2021 Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System**  On August 4, 2020, the Centers for Medicare & Medicaid Services (CMS) published the calendar year (CY) 2021 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule.  Among notable changes, CMS proposes to pay the average sales price (ASP) minus 28.7 percent for 340B drugs; change the expansion exception process for a subset of physician-owned hospitals; expand the prior authorization process to include two new categories of services reimbursed under the OPPS; and eliminate the inpatient only list.  **Proposed Hospital Outpatient Department and ASC Payment Updates**  CMS proposes an increase of 2.6% for OPPS payment rates in CY 2021, which it estimates will result in a total of approximately $83.9 billion in payments to OPPS. CMS will continue the statutory 2 percentage point reduction for hospitals failing to meet the hospital outpatient department quality reporting requirements.  CMS proposes an increase of 2.6% for ASC payment rates in CY 2021, which is consistent with CMS' policy for CYs 2019 through 2023 to update the ASC payment system using the hospital market basket update. CMS estimates this will result in a total of approximately $5.45 billion in payments to ASC providers.  **Elimination of the Inpatient Only List**  The inpatient only (IPO) list was created to identify services that require inpatient care because of the invasive nature of the procedure, the need for postoperative recovery time, or the underlying physical condition of the patient. CMS concluded that the list is not necessary to identify services that require inpatient care because of changes in medical practice, including new technologies and innovations.  Beginning with 2021, CMS proposes to eliminate the IPO list over 3 calendar years, starting with the removal of 300 musculoskeletal-related services in 2021. They are asking for comments on whether 3 years is an appropriate timeframe for the elimination; on whether any other services are candidates for removal in CY 2021; and on the sequence of removal over the 3 years. CMS also proposes to continue the 2-year exemption from site-of-service claims denials and recovery audit contractor referrals for services removed from the IPO. Given the significant surge in the number of newly removed services because of the proposed elimination of the IPO, CMS requests comments on whether the 2-year exemption is still adequate.  Several inpatient spine procedures are identified for transition out of the IPO list as part of the proposed change.  **Payment for 340B Drugs and Biologics**  CMS adopted a policy to pay average sales price (ASP) minus 22.5% for 340B-acquired drugs, including when furnished in nonexcepted off-campus provider-based departments paid under the Physician Fee Schedule (PFS). In last year's rule, CMS acknowledged the ongoing litigation relating to the lower payment amount, including a district court ruling that the agency exceeded statutory authority in adjusting the payment rate for 340B drugs.  CMS conducted a survey to gather data on hospital acquisition costs for 340B drugs following the court ruling that found that CMS acted beyond its statutory authority but also acknowledged that CMS might base the payment amount of average acquisition cost when survey data are available.  In early August 2020, the U.S. Court of Appeals for the District of Columbia Circuit reversed the lower district court's ruling and held that CMS did in fact reasonably interpret the Medicare statute as authorizing the rate reductions under a "general adjustment authority" with the purpose "to reimburse hospitals for their acquisition costs accurately."  Based on the results of this survey of hospital acquisition costs for 340B drugs, CMS is now proposing the pay for 340B drugs for CY 2021 and subsequent years at ASP minus 34.7%, plus an add-on of 6% of the ASP. This results in a net payment rate of ASP minus 28.7% for 340B drugs. For biosimilars, CMS is proposing to set net reimbursement at ASP minus 28.7% of the biosimilar's ASP, not minus 28.7% of the reference product's ASP.  Similar to the previous policy, rural sole community hospitals, PPS-exempt cancer hospitals, and children's hospitals are exempt from this lower 340B reimbursement. Wholesale Acquisition Cost will be used for products without an ASP available.  **Hospital Star Ratings**  CMS proposes a methodology to calculate the Overall Hospital Quality Star Rating utilizing data collected on hospital inpatient and outpatient measures that are publicly reported on a CMS website. CMS also proposes to update and simplify how the ratings are calculated, reduce the total number of measure groups, and stratify the readmission measure group based on the proportion of dual-eligible patients.  **Prior Authorization**  Last year, CMS finalized a proposal to establish a process through which hospitals must submit a prior authorization request for a provisional affirmation of coverage before a covered outpatient service is furnished to the beneficiary and before the claim is submitted for processing. The change applied to five categories of services: blepharoplasty, botulinum toxin injections, panniculectomy, rhinoplasty, and vein ablation.  This year, the agency proposes to expanded prior authorization requirements for two additional services: cervical fusion with disc removal and implanted spinal neurostimulators to curb unnecessary utilization. Services in these two categories would be subject to prior authorization for dates of service on or after July 1, 2021. CMS estimates annual Medicare savings of more than $31.8 million.  It is likely that this policy will expand in future rulemakings.  **Site-Neutral Payment Policy for Clinic Visits**  As finalized in the CY2019 OPPS/ASC final rule, CMS completed the implementation of the 2-year phase-in of applying the Medicare Physician Fee Schedule (MPFS) rate for the clinic visit service (G0463 – Hospital outpatient clinic visit for assessment and management of a patient) when provided at an off-campus provider-based department and reimbursed under OPPS. This clinic visit is the most common service billed under OPPS and typically occurs in the physician's office. CMS instituted the proposal based on its authority to restrict unnecessary increases in the volume of covered services.  In September 2019, a federal district court sided with hospital plaintiffs, ruling that CMS lacked statutory authority to implement the change. However, on July 17, 2020, the U.S. Court of Appeals for the District of Columbia Circuit ruled in favor of CMS, holding that the agency's regulation was a reasonable interpretation of the statutory authority to adopt a method to control unnecessary increases in the volume of the relevant service. In light of this recent court ruling, CMS will continue the site-neutral policy in 2021. CMS has not released information on how or whether it will address reprocessing 2019 claims that were previously reprocessed at the higher OPPS rate.  **Physician-Owned Hospitals**  Generally, physician-owned hospitals (POHs) may not increase the number of operating rooms, procedure rooms, and beds beyond those that were licensed on March 23, 2010 (the Affordable Care Act enactment date). In the original statutory language, an exception process to this prohibition was included for POHs that qualify as an "applicable hospital." Later, an additional exception was created for POHs that qualified as a "high Medicaid facility." The requirements and statutory direction for these two exceptions were different, but CMS implemented a single process to address both.  In this rule, CMS proposes to remove certain expansion limits for "high Medicaid facilities" as part of its Patients Over Paperwork initiative. CMS proposes the following flexibilities applicable only to qualifying Medicaid facilities:   * Hospitals can request an exception to the prohibition of expansion at any time, provided that the facility has not submitted another exception request that is pending a CMS decision. This proposal would eliminate the restriction that exceptions can only be submitted every 2 years for Medicaid hospitals. * If CMS approves a hospital's request for expansion, the hospital can exceed 200% of its baseline number of beds, operating rooms, and procedure rooms. * Requests for expansion may include facilities that are not located on the hospital's main campus. * A bed counts toward a hospital's baseline number if the bed is considered licensed for purposes of state licensure.   A hospital qualifies as a "high Medicaid facility" when a hospital:   * is not the only hospital in a county * has an annual percent of total inpatient admissions under Medicaid that is estimated to be greater than any other hospital located in the county in which the hospital is located for the three most recent 12-month periods * does not discriminate against beneficiaries of federal healthcare programs and does not permit physicians practicing at the hospital to discriminate against such beneficiaries   CMS solicits comments on whether it should maintain the opportunity for community input on any requests for exceptions to the expansion process submitted by "high Medicaid facilities."  **Pass-Through Time Extension Because of COVID-19**  CMS is requesting comments on whether pass-through status should be extended for an additional time period because of the effects of COVID-19 on the use of those items with pass-through status. CMS is also proposing to clarify that a new medical device is part of the U.S. Food and Drug Administration's Breakthrough Devices Program and has received marketing authorization for the indication covered by the Breakthrough Device designation and does not need to meet the substantial clinical improvement criterion.  **Comprehensive Ambulatory Payment Classifications**  CMS has proposed creating two new Comprehensive Ambulatory Payment Classifications (APCs), including C-APC 5378 (Level 8 Urology and Related Services) and C-APC 5465 (Level 5 Neurostimulator and Related Procedures).  **Two-Midnight Rule**  CMS has proposed to continue a 2-year exemption from the “2 Midnight Rule” which is determined by the Beneficiary and Family-Centered Care Quality Improvement Organizations referrals to Recovery Audit Contractors (RACs) and RAC reviews for "patient status" (that is, site-of-service) for procedures that are removed from the IPO list under the OPPS beginning on January 1, 2021. The agency seeks comments on whether the 2-year exemption period continues to be appropriate or whether a longer or shorter exemption period for procedures removed from the IPO list may be more warranted.  ISASS will provide comments to CMS by the comment deadline of October 5, 2020.  To read the CMS press release, click here: <https://www.cms.gov/newsroom/fact-sheets/cy-2021-medicare-hospital-outpatient-prospective-payment-system-and-ambulatory-surgical-center>  To read the Full Rule, click here: <https://www.federalregister.gov/documents/2020/08/12/2020-17086/medicare-program-hospital-outpatient-prospective-payment-and-ambulatory-surgical-center-payment> |
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| **CMS Expands COVID-19 Telehealth Provisions to Skilled Nursing Facility Residents**  The current COVID-19 public health emergency does not waive any requirements related to Skilled Nursing Facility (SNF) Consolidated Billing (CB); however, the Centers for Medicare & Medicaid Services added CPT codes 99441, 99442, and 99443 to the [list of telehealth codes](https://lnks.gd/l/eyJhbGciOiJIUzI1NiJ9.eyJidWxsZXRpbl9saW5rX2lkIjoxMDYsInVyaSI6ImJwMjpjbGljayIsImJ1bGxldGluX2lkIjoiMjAyMDA3MzEuMjUxNTU0MDEiLCJ1cmwiOiJodHRwczovL3d3dy5jbXMuZ292L01lZGljYXJlL01lZGljYXJlLUdlbmVyYWwtSW5mb3JtYXRpb24vVGVsZWhlYWx0aC9UZWxlaGVhbHRoLUNvZGVzIn0.8S9A5zHtBGBca3XXy8kbT_P8kWgWbl4GdhD8pqjKrOk/s/935658752/br/81781365866-l) coverable under the waiver during the COVID-19 public health emergency. These codes designate three different time increments of telephone evaluation and management service provided by a physician. You can bill for these physician services separately under Part B when furnished to a SNF’s Part A resident.  Medicare Administrative Contractors (MACs) will reprocess claims for CPT codes 99441, 99442 and 99443 with dates of service on or after March 1, 2020, that were denied due to SNF CB edits. You do not have to do anything. If you already received payment from the SNF for these physician services, return that payment to the SNF once the MAC reprocesses your claim. |