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center; however, this may create additional barriers and decrease the chances of the patient actually receiving the medication while on antibiotic therapy for CDI. Additional barriers include: the medication most often requires a prior authorization; and the fact that there is an increased risk of mortality in those with underlying CHF, which is a prevalent disease state in those who are hospitalized. Additional comparative clinical trials with other agents that have been shown to reduce recurrence, such as fidaxomicin, will help to better determine the utility of bezlotoxumab in the future.

At the time of this writing, Ms. Zuschnitt was on a clinical rotation in the Center for Pharmaceutical Care at Allegheny General Hospital. For any questions concerning this article, please contact Tucker Freedy, PharmD, at Allegheny Health Network, Allegheny General Hospital, Center for Pharmaceutical Care, Pittsburgh, Pa., (412) 359-3192 or tucker.freedy@ahn.org.

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Legal Report

Medicare physician fee schedule changes: 2020

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On July 29, 2019, the Centers for Medicare and Medicaid Services (CMS) issued the proposed Medicare Physician Fee Schedule (PFS) changes for the 2020 calendar year.

A. Payment for evaluation and management (E/M) services

The E/M proposals will probably be the most complicated and will impact the most physicians. I will outline them here and then present a later *Bulletin* article dedicated specifically to E/M Services.

- The CPT coding changes retain five levels of coding for established outpatient, but reduce the number of levels to four levels of E/M visits for new patients.
- The code definitions are revised, as well as the times and medical decision-making process for all codes.
- CMS will require performance of a history and physical (H&P) or exam only as medically appropriate, but that does not mean CMS and other third-party auditors will not require a sufficient H&P to justify the higher level visits, so that change might be slightly illusory.

• E/M coding will allow clinicians to choose the E/M visit level based upon either medical decision-making or time, but obviously you must continue to sufficiently document the record to support either your medical decision-making or the time recorded. Just as a cautionary note, you must be careful not to choose "time coding" that ends up being longer than your available office hours. We all have heard the stories about the E/M visits adding up to more hours than were allotted in the day.

B. Physicians supervision requirements for physician assistants (PAs)

CMS is proposing to modify its regulations on physician supervision of PAs to give PAs greater flexibility consistent with the scope of practice permitted by state law. CMS supervision requirements have traditionally been tied to categories first proposed by CMS in 1986 for the supervision of diagnostic tests, i.e., general, direct and personal. General supervision always has been the most lenient, meaning that the services of the PA must be furnished under a physician's overall direction and control, but that the physician's presence was not required during the performance of the services.

Just by way of background, direct supervision has traditionally been used for "incident to" billing, requiring that the physician be in the office suite and available to take over the care of the patient if necessary. Personal supervision meant that the physician must be present during the performance of the supervised procedure. In Pennsylvania, collaboration requires some level of supervision essentially similar to general supervision. Remember that allowing PAs to bill independently only permits billing for services provided without the presence of a physician at 85% of the Medicare physician fee schedule. This does not mean that a physician assistant can practice independently because some type of general supervision still was required.

CMS is responding to comments, presumably from advocates for expanding the scope of practice of non-physician practitioners, arguing that state law has provided an enhanced scope of practice and greater independence in flexibility for non-physician practitioners. That might be a bit

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of an exaggeration; unless state law allows independent practice without supervision, the typical collaboration required by state law is not, in my opinion, significantly different from the general supervision requirement. However, that will be a state-by-state issue.

C. 2020 conversion factor

The increase in the Medicare conversion factor was miniscule. It was increased by $.05 from $36.04 per RVU to $36.09. Everybody is aware that Medicare pays by adding the overhead, malpractice and work RVUs, and then multiplying the total by the Medicare conversion factor. You may recall the wild fluctuation mandated in the conversion factor by the Sustainable Growth Rate (SGR) formula was repealed in 2015.

D. Opioid Use Disorder (OUD) treatment

In accordance with the Substance Use Disorder Prevention that Prompts Opioid Recovery and Treatment for Patients in Communities (SUPPORT) Act, CMS is establishing a new Medicare Part B benefit for OUD treatment, that includes medications for Medication Assistant Treatment (MAT) furnished by Opioid Treatment Programs (OTPs). To meet the support Act requirements, CMS has proposed:

- Definitions for OTP and OUD treatment services
- Enrollment policies for OTPs
- Methodology and estimated bundled payment rates for OTPs that vary by medication used and service intensity
- Flexibility to deliver counseling and therapy via telehealth coverage
- Zero beneficiary co-payment for a time-limited duration

E. Review and verification of medical record documentation

In an attempt to reduce the paperwork burden, CMS is proposing what they refer to as "broad modifications to the documentation policy" so that all clinicians (physicians, PAs, CRNPs, CNS and midwives) can establish a medical record by a signed and dated note indicating they reviewed and verified prior medical notes. CMS has added a medical record documentation statement specifying that, when furnishing professional services, a clinician may review and verify (sign/date) notes in the patient's medical record made by other physicians, residents, nurses, students, or other members of the medical team, including notes documenting that practitioner's presence and participation in the services, rather than fully redocumenting the information. However, the comments specifically note that the modification does not modify the scope of, or standards for, the documentation that is needed in the medical record to demonstrate medical necessity of services, and are otherwise for purposes of appropriate medical record keeping.

This is intended to mitigate the problems arising from EHR duplication of prior notes without adequate verification. Apparently, the use of "template notes" is no longer being encouraged. Some of you may have been involved in reimbursement audits in which the third-party carriers allege that the medical records were duplicates of earlier medical records rather than "new" medical records. This new policy may change the process, but it will not relieve the burden of reviewing prior medical records and noting that accordingly; you must avoid the trap of simply reverifying medical records that are no longer applicable.

F. Comment solicitation

CMS also is soliciting comments in a number of different areas, but remember that the solicitation of comments is not a proposed rule-making; it merely indicates CMS is considering a future proposed change.

- CMS is solicitating comments to potentially align the Medicare shared savings program quality performance scoring methodology more closely with the merit-based incentive payment system (MIPS).
- CMS is soliciting comments on potential changes to the Stark Act advisory opinion process.

G. Conclusion

The next *Bulletin* article will discuss the details of the E/M changes.

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