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The Medicare Physician Fee Schedule for 2019

In This Issue

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On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) released an advanced copy of the final rule announcing policies and payment levels for the Medicare Physician Fee Schedule for 2019, implementing policy changes to the Quality Payment Program (QPP) and announcing other miscellaneous payment policies for Medicare Part B items and services. The final rule is scheduled to be published in the Federal Register on November 23, 2018 and CMS will accept comments from stakeholders through December 31, 2018.

The final rule implements policies that are aimed at continuing overarching efforts by CMS to reduce regulatory burdens on providers, expand the availability of remote care and telehealth services, address concerns about the high cost of prescription drugs and promote value based care. Although the final rule contains provisions addressing a variety of payment changes, this alert addresses those of broadest applicability to health care providers:

- Changes in the Documentation, Payment and Coding of Evaluation and Management Visits for the Office and Outpatient Setting
- Expansion of Medicare Coverage for Communication Technology-Based Services and Telehealth Services
- Conversion Factor and Implementation of Updated Market-Based Supply and Equipment Pricing
- Reduction in the Add-On Payment for Part B Drugs Paid Based on Wholesale Acquisition Cost
- 2019 Payment Rates for Nonexcepted Items and Services Delivered by Nonexcepted Off-Campus Provider-Based Hospital Outpatient Departments
- Implementation and Request for Comment on New Opioid Treatment Program Medicare Benefit Category
- Technical Revisions to the Physician Self-Referral Law
- Amendments to the Quality Payment Program for Performance Year 2019

Changes in the Documentation, Payment, and Coding of Evaluation and Management Visits

CMS proposed ambitious reforms to the documentation, coding and payment of evaluation and management (E/M) visits in the office and outpatient settings. Currently, Medicare pays for E/M visits in the office and outpatient setting based on a set of CPT codes that describe

five levels of visits for both new and established patients. As visits increase in complexity from level one to level five the amount of Medicare payment and required documentation to support the visit level also increase. Today, practitioners are required to document the required medical information to support the level of E/M visit they bill by using either the 1995 or 1997 documentation guidelines, which document a patient's history, the physical examination and the medical decision making process.

If finalized in its entirety, the proposed rule would have implemented policies that reduced documentation requirements for E/M visits, consolidated the payment for level two to level five E/M visits into a single physician fee schedule payment rate and created several add-on codes to account for visit complexity and prolonged E/M visits. The Agency also proposed a multiple procedure payment reduction policy (MPPR) and technical adjustments to create a separate practice expense per hour input for E/M services used in the methodology for allocating indirect practice expense (PE) costs. CMS did not finalize the MPPR or the changes to the practice expense per hour provisions.

After considering the public comments, CMS will only implement limited E/M documentation reduction policies for 2019 and announced it will delay the effective date of all other proposed E/M documentation, payment and coding reforms until 2021.

Documentation Reforms Effective in 2019

Although CMS will still require practitioners to adhere to the 1995 or 1997 version of the E/M documentation guidelines to support Medicare coverage of E/M visits in 2019 and 2020, the Agency finalized two proposals to reduce redundant documentation and eliminated the requirement to document the medical necessity for an in home rather than an office visit.

Beginning in 2019, the Agency will not require practitioners to re-enter information already contained in a patient's medical record in two instances. First, when treating an established patient, a practitioner will not need to re-document information that is already included in the patient's medical record from a previous visit. Instead, the practitioner may focus their documentation on relevant incremental changes or stability in the patient's condition. Re-recording a defined list of required elements for payment will not be necessary if there is evidence in the medical record that the practitioner reviewed and updated the information as needed. Second, CMS will not require a practitioner to re-enter information about a new or established patient's medical history or primary complaint if the practitioner indicates they have reviewed and verified the information that has already been entered by an ancillary provider or the beneficiary.

Other E/M Documentation, Coding, and Payment Reforms Effective in 2021

The vast majority of documentation, payment and coding reforms for E/M visits will be implemented in 2021. The final rule establishes three payment levels for E/M services instead of the current five levels. Beginning in 2021, level two through level four E/M visits will be consolidated into a single payment level while level five and level one E/M visits will retain separate payment levels. This is a slight modification from the proposed rule, which would have consolidated level two through level five E/M visits into a single payment level. CMS made this modification in response to comments that argued consolidating payments for level two though level five E/M visits into a single rate would not provide adequate resources to address the needs of medically complex patients.

As a continuation of the Agency's overall goal to reduce regulatory burdens, CMS will allow practitioners to use the 1995 or 1997 documentation guidelines, use only the medical decision making criteria, or use time based standards to document level two through five E/M visits beginning in 2021. Additionally, the required documentation for any level two through level four visit will only need to meet the standards for a level two visit.

CMS will implement two new add-on codes that practitioners may use to reflect the complexity of primary care and other non-procedural specialty visits or reflect the additional resources required in providing an "extended visit" to a patient. Each of the new add-on codes will only be available when practitioners bill for a level two through four E/M service.

Expansion of Coverage for Technology-Based Communication Services and Medicare Telehealth Services

The final rule creates coverage for three new types of technology-based communication services, which continue the expansion of Medicare coverage for services that are not delivered during a face-to-face interaction between a practitioner and a patient. Upon meeting the necessary requirements, Medicare will cover the following services in 2019: (1) Virtual Check-Ins (HCPCS code G2012), (2) Remote Evaluation of Pre-Recorded Patient Information (HCPCS code G2010)[1] and (3) Interprofessional Internet Consultations (CPT 99451, 99452, 99446, 99447, 99448 and 99449).

Although these services may be commonly referred to as telehealth by observers, CMS continues to apply a narrow interpretation of the language defining the Medicare telehealth benefit under Section 1834(m) of the Social Security Act. The Agency continued its past practice of providing coverage for non-face-to-face services as part of ongoing care management because CMS believes Section 1834(m) applies to "professional services explicitly enumerated in the statutory provisions, like professional consultations, office visits and office psychiatry

[1] CMS used HCPCS code GRAS1 to refer to this service in the proposed rule.

services" instead of services furnished remotely using communication systems. This interpretation allows each of the technology-based remote care services finalized by the Agency to be delivered to Medicare beneficiaries without meeting Section 1834(m)'s restrictions.

The final rule also addresses policies where the Medicare telehealth benefit applies. CMS finalized the addition of two prolonged preventive service codes (G0513 and G0514) to the list of permitted telehealth services and implementing legislative directives contained in the Bipartisan Budget Act of 2018 (BBA of 2018) and the SUPPORT for Patients and Communities Act (SUPPORT Act).

The BBA of 2018 expanded the scope of the telehealth benefit for ESRD patients receiving in-home dialysis and for Medicare beneficiaries requiring acute stroke services or mobile stroke care. Beginning January 1, 2019, patients with ESRD that are on home dialysis will be eligible to receive their monthly ESRD-related clinical assessment via telehealth because hospital and CAH-based renal dialysis facilities and the homes of ESRD beneficiaries will now be designated as telehealth originating sites for the limited purpose of receiving the assessment. Medicare will still require a face-to-face assessment once every three months. The final rule also lifts Section 1834(m)'s geographic restrictions and originating site requirements for telehealth services for the diagnosis, evaluation or treatment of an acute stroke and adds mobile stroke units to the list of telehealth originating sites.

CMS also implemented a provision in the SUPPORT Act, which removes the geographic originating site requirements and adds beneficiary homes to the list of originating sites for telehealth services that are used in the treatment of individuals diagnosed with a substance use disorder or a co-occurring mental health disorder. CMS is seeking comment on this provision, which was made on an Interim Final Rule basis and would become effective on July 1, 2019.

Conversion Factor and Implementation of Updated Pricing Information for Equipment and Supply Inputs

The final rule sets the 2019 physician fee schedule conversion factor at $36.0391, which reflects an increase from the 2018 conversion factor of $35.9996. The conversion factor is used to convert the assigned relative value units for a service to a dollar value.

CMS also used its authority under Section 220(a) of the Protecting Access to Medicare Act of 2014 to perform a market research analysis to update the pricing inputs for equipment and supplies used as part of the calculation of direct PE relative value units. CMS engaged an independent consultant, StrategyGen to perform the analysis and proposed new pricing inputs for each of the approximately 1,300 supplies and 750 equipment items used as PE inputs. CMS adopted the new pricing inputs, with some amendments and modifications that are listed in Table nine of the final rule. With limited exceptions, CMS will phase in the new values over a four-year period with one quarter of the impact of any change in the pricing input implemented in each year through 2022.

Reduction in the Add-On Payment for Part B Drugs paid through the Wholesale Acquisition Cost Formula

CMS continued the Trump Administration's ongoing efforts to combat high drug prices by finalizing a policy to reduce the add-on payment for Part B drugs paid under the Wholesale Acquisition Cost (WAC) methodology from WAC +6% to WAC +3%. The WAC methodology is used to provide payment for new Part B drugs, when an average sale price is not available and when a Part B drug's WAC is less than the drug's average sales price (ASP). Despite these reforms, the vast majority of Part B drugs will continue to be paid based on the average sale price plus 6% formula.

2019 Payment Rates for Nonexcepted Items and Services Delivered by Nonexcepted Off-Campus Provider-Based Hospital Outpatient Departments

Off-campus provider-based hospital outpatient departments that are not excepted from section 603 of the Bipartisan Budget Act of 2015 (BBA of 2015) are required to be paid under an applicable payment system and are prohibited from receiving payment through the hospital outpatient prospective payment system (OPPS). CMS identified the physician fee schedule as the applicable payment system for the purpose of implementing section 603 beginning in 2017.

CMS uses a relativity adjustment to calculate payments for nonexcepted items and services furnished by nonexcepted departments. The relativity adjustment is used to calculate payment levels for nonexcepted items and services at a designated percentage of the hospital outpatient department rate. For 2019, CMS finalized a relativity adjustment of 40% for nonexcepted items and services delivered in nonexcepted departments, meaning these services will be paid at 40% of the OPPS rate. The 40% relativity adjustment is the same relativity adjustment used to calculate payments in 2018.

Implementation and Request for Comment on New Opioid Treatment Program Medicare Benefit Category

Section 2001 of the SUPPORT Act creates a new Medicare benefit category for opioid use disorder treatment services furnished by Opioid Treatment Programs (OTPs) that provide qualifying services to Medicare beneficiaries. An OTP must be enrolled in Medicare, meet conditions the Secretary deems

necessary to ensure the health and safety of individuals receiving services and possess a certification from the Substance Abuse and Mental Health Services Administration (SAMHSA) or accreditation by a SAMHSA approved entity. The Agency requests comments as part of the interim final rule to support this provision's implementation.

Technical Revisions to the Physician Self-Referral Law

The final rule added regulatory language that allows the Stark Law's requirement that a compensation arrangement be in writing can be satisfied by a collection of documents signifying the parties' intent. A new "Written Requirement Clarified" section, codified at Section 1877(h)(1)(D) of the Social Security Act, provides that for a compensation arrangement to be in writing, such requirement shall be satisfied by such means as determined by the Secretary, including by a collection of documents, such as contemporaneous documents evidencing the course of conduct between the parties involved. The final rule confirmed that this was long-standing CMS policy, and added similar language to 42 CFR §411.354(e) that allows the writing requirement to be satisfied.

The BBA of 2018 also modified the Stark Law signature requirements to allow for signatures to be obtained within 90 consecutive calendar days of when the compensation arrangement became non-compliant, so long as all other requirements were met. While this was true for certain special rules for certain arrangements at §411.353(g)(1), the regulations previously only allowed an entity to avail itself of this exception once every three years with respect to the same referring physician. The final rule amends 42 CFR 411.353(g) to eliminate the three year limitation and implements the 90 day rule across all compensation arrangement exceptions effective February 9, 2018.

Amendments to the Quality Payment Program for Performance Year 2019

CMS announced that an estimated 798,000 clinicians will be MIPS-eligible in the 2019 Performance Period, an increase of almost 148,000 from the estimate provided in the Proposed Rule. This change is primarily motivated by: (1) expansion in the definition of health care professionals eligible to participate in MIPS (now includes physical therapists, occupational therapists, speech pathologists, audiologists, dieticians, and clinical psychologists); (2) change in the Low Volume Threshold Exception; and (3) new opt-in policy to allow certain clinicians who see a low volume of Medicare patients (and as a result are exempt from MIPS) to voluntarily participate in MIPS.

In addition to the expansion of participating clinicians, a number of other notable changes occurred:

- Makes adjustments to the MIPS performance thresholds, raising the minimum score necessary to avoid negative MIPS adjustment to 30 points out of 100 from the previous standard of 15 points out of 100 and raises the minimum score necessary to obtain MIPS "exceptional performance" bonuses to 75 points out of 100 from 70 points out of 100.
- Increases the MIPS Cost Performance Category weight to 15% from the previous 10%, decreases Quality Performance Category weight to 45% and maintains the Promoting Interoperability Performance Category (formerly called Advancing Care Information) and Improvement Activities Performance Category weights at 15% and 25%, respectively, for the 2019 reporting period.
- Adds eight new measures for the MIPS Cost Performance Category that are based on clinical episodes of care to allow for greater flexibility in meeting performance criteria. The Cost Performance Category previously used only the Total Per Capita Cost and Medicare Spending per Beneficiary measures to assess cost performance. The addition of episodic measures will promote cost measurement on more clinically relevant measures.
- Adds eight new MIPS Quality Measures, but removes 26 current MIPS Quality Measures from the list of measures under the MIPS Quality Performance Category. The added measures include four patient reported outcome measures and six measures that are deemed high priority measures by CMS. This was one of the most negatively commented upon provisions because of the potential for decrease in quality reporting flexibility for specialists.
- Finalizes a proposal that allows CMS to remove measures when they reach an extremely topped out status, which occurs when the average mean performance for a measure falls within the 98-100 percentile range. When CMS identifies a measure as extremely topped out it may propose the measure for removal from the MIPS measure set in the next rulemaking cycle regardless of how long it has been a measure.
- Modifies the MIPS "Promoting Interoperability" (formerly called Advancing Care Information) performance category to support greater EHR interoperability and patient access to their health information and aligns this performance category for clinicians with the new Promoting Interoperability Program for hospitals. CMS is requiring providers to use of 2015 Edition Certified EHR Technology (CEHRT) beginning with the 2019 MIPS performance period. The Agency believes the transition to 2015 Edition CEHRT will facilitate enhanced exchange and sharing of information about patient care among providers and their patients and between health care providers.

- The Agency continued to promote policies to support small practices in their participation in MIPS. CMS retained the MIPS small practice bonus and embedded it within the scoring for the MIPS quality performance category instead of continuing it as a standalone scoring bonus. Small practices will continue to have the opportunity to participate in MIPS as a virtual group and use the Medicare Part B claims submission method to report MIPS data to CMS.
- Maintains CMS's focus on the use of certified electronic health records technology by requiring an Alternative Payment Model to have at least 75% of eligible clinicians (previously 50%) use CEHRT to qualify as an Advanced Alternative Payment Model ("APM").
- Maintains the revenue-based nominal amount threshold to qualify as an Advanced APM at 8% through performance year 2024 (although CMS appeared to favorably view comments that it should consider raising the revenue-based nominal amount threshold to 10% in 2025).
- Eliminates the requirement that eligible clinicians participating in Other Payer Advanced APMs re-submit payment arrangement information through annual attestation. Rather, clinicians are required to submit payment arrangement information only if the arrangement undergoes any changes.
- Allows Advanced APM Qualifying Participant determinations for the All-Payer Option to be made at the TIN level in addition to the APM Entity and individual levels.

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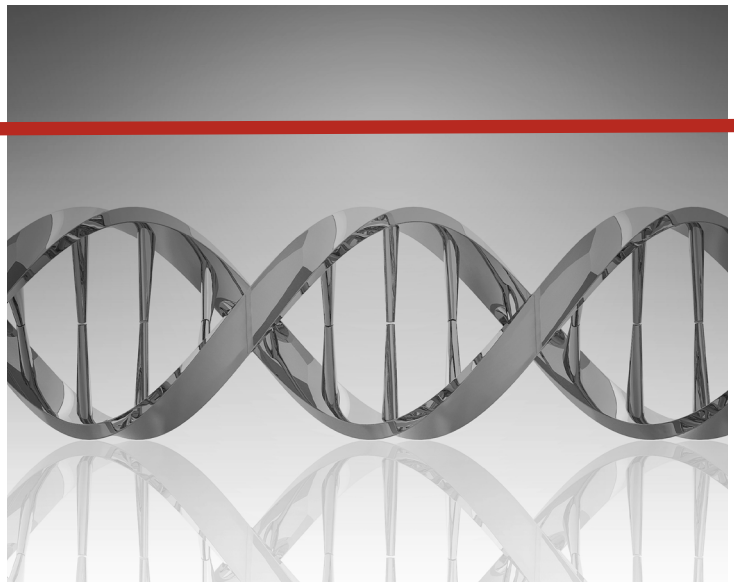

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