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Summary of the CY 2019 Medicare Physician Fee Schedule Final Rule

The Centers for Medicare & Medicaid Services issued its calendar year (CY) 2019 Medicare physician fee schedule (PFS) final rule on November 1, 2018. Most provisions of the rule will take effect beginning January 1, 2019. The following provides an overview of key provisions included in the rule.

Payments for Non-Excepted Services at Off-Campus Hospital Provider-based Departments (PBDs)

CMS did not finalize any changes related to the site neutral payment policy under Section 603 of the Bipartisan Budget Act (BiBA) of 2015. Non-grandfathered off-campus PBDs will continue to bill for non-excepted services on the institutional claim using a PN modifier and will be reimbursed at 40 percent of the OPPS amount for CY 2019.

Conversion Factor:

The PFS payment update for CY 2019 is 0.11 percent, including the 0.25 percent increase required by MACRA and a budget-neutrality adjustment of -0.14 percent. The resulting conversion factor is $36.0391 for CY 2019.

Evaluation and Management (E/M) Documentation and Payment:

CMS did not finalize its proposal to collapse the payment rates for the five levels E/M into two levels. Instead, the agency will continue to pay a single rate for levels one and five, and will pay a blended rate for levels two through four using the weighted average of the current payment input assigned to each of those levels based on the most recent give years of utilization data. Providers will only be required to meet the level two standard of documentation for level two through four visits.

CMS finalized a number of other changes related to E/M documentation and coding, including:

- Removing the requirement that medical records must document the medical necessity of furnishing a home visit rather than an office visit;
- Allowing providers to document E/M visits using the current 1995 or 1997 documentation guidelines or medical decision-making or time with a patient beginning in CY 20121;
- Requiring providers to document only what has changed since the patient's first visit or pertinent items that have not changed; and
- No longer requiring providers to re-enter information in the medical records regarding new and established patients' chief complaint and history if that information was entered by ancillary staff or the beneficiary.

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Telehealth:

Some of the more sweeping changes in the final rule relate to telehealth. CMS finalized a number of policies intended to promote telehealth by recognizing communication technology-based services. Specifically, CMS will now provide separate payment under the PFS for brief communication technology-based check-ins between providers and patients and providers' remote evaluation of patients' pre-recorded video and/or images submitted using store and forward technology. CMS also finalizes separate payment for six CPT codes describing interprofessional/internet assessment and management services provided by a consulting physician. Additionally, the agency finalized three codes for remote patient monitoring services, including the set-up, patient education, and use and interpretation of remote physiologic monitoring equipment that transmits patient information on chronic conditions. Lastly, CMS adds two codes to the list of Medicare telehealth services and extends the time period for requesting that services be added until February 10th of each year.

CMS also implements changes to comply with the BiBA of 2018 and the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) Patients and Communities Act. CMS will now consider renal dialysis facilities and individuals' homes as qualified originating sites for home dialysis monthly end-stage renal disease-related clinical assessments and eliminates geographic requirements related to renal dialysis services. CMS also adds a new modifier related to telehealth for identifying acute stroke telehealth services. Originating site geographic requirements are also eliminated for telehealth services for treatment of individuals diagnosed with a substance use disorder or a co-occurring mental health disorder beginning July 1, 2019.

Quality Payment Program (MIPS/APMs under MACRA):

CMS finalizes a number of changes related to the Merit-Based Incentive Payment System (MIPS) and advanced payment models (APMs) under MACRA. For example, the BiBA permitted CMS to apply a more gradual increase to the weight associated with the MIPS cost category. Thus, CMS adopts a category weight of 15 percent for 2021. CMS also expands the list of clinicians to which MACRA applies to include physical therapists, occupational therapists, clinical psychologists, qualified speech-language pathologists, qualified audiologists, and registered dietician or nutrition professionals.

The BiBA required that payment adjustments and the low-volume threshold be applied to covered professional services instead of items and services. Thus, CMS amends the low-volume threshold. Clinicians will now be excluded from MIPS if they meet one of the following: (i) have $90,000 or less of allowed charges for covered professional services; (ii) provide care to 200 or fewer Medicare beneficiaries; or (iii) provide 200 or fewer covered professional services under the PFS.

CMS also expands eligibility for facility-based clinicians. Specifically, the agency will include services in on-campus hospital outpatient settings (POS code 22) so long as the clinician also bills at least one service using the inpatient (POS code 21) or emergency department (POS code 23). Thus, facility-based measurement will be available to clinicians that have 75 percent of their covered professional services provided in the inpatient hospital, on-campus outpatient hospital, or emergency department setting and group practices will be eligible provided that 75 percent of

clinicians in the practice meet this revised definition. Clinicians and practices will automatically be scored at the facility level unless their performance under MIPS is better and they choose to submit that information.

No changes are made to the options for reporting MIPS data; however, CMS does change the verbiage associated with the options. Submission type will be used to describe the way in which the data is submitted. Submitter type will refer to the entity that submits the data. Collection type will refer to quality measures with comparable specifications and data completeness requirements.

Aside from the Promoting Interoperability (PI) category and the aforementioned change to the cost category, the only significant change is the removal of 26 measures from the MIPS measure set consistent with CMS' Meaningful Measures initiative. For the PI category, CMS will require all MIPS-eligible clinicians to use the 2015 Edition certified EHR. CMS finalized a reporting period of any continuous 90-day period. CMS also finalizes a new scoring methodology consistent with changes for hospitals that were included in the IPPS final rule.

The scoring methodology will be based on four objectives with measures derived from Stage 3 of meaningful use. The four objectives are: Electronic Prescribing; Health Information Exchange; Provider to Patient Exchange; and Public Health and Clinician Data Exchange. Clinicians would still be required to meet the criteria for protecting patient health information. The proposed measures and scoring methodology is as follows:

Objective	Measures	Maximum Points
e-Prescribing	e-Prescribing	10 points
	Query of PDMP	5 bonus points
	Verify Opioid Treatment Agreement	5 bonus points
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information (sending a Summary of Care)	20 points
	Support Electronic Referral Loops by Receiving and Incorporating Health Information (receiving a Summary of Care and Clinical Information Reconciliation)	20 points
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 points
Public Health and Clinical Data Exchange	Choose two of the following: Immunization Registry Reporting Electronic Case Reporting Public Health Registry Reporting Clinical Data Registry Reporting Syndromic Surveillance Reporting	10 points

Source: American Hospital Association

Lastly, CMS established the various performance threshold related to bonuses and penalties. The performance threshold – the level at which there are bonuses for exceeding and penalties for falling below – is set at 30 points for CY 2021 payment. Providers who are achieve or are below 25 percent of the performance threshold will be subject to the maximum penalty of seven percent. Providers who obtain 75 points or more would be eligible for the exceptional performance bonus.

CMS makes relatively few changes regarding APMs. Beginning in CY 2019, CMS is increasing the percentage of eligible clinicians within an APM that must use certified EHR technology from 50 percent to 75 percent. Additionally, advanced APM models must use at least one outcome measure that is on the MIPS measure list, endorsed by a consensus-based entity, or otherwise determined to be evidence-based. CMS also extends the eight percent revenue based standard for risk through CY 2024.

Payment for New Drugs:

Currently, new non-pass-through Part B drugs and biologicals that are not acquired under the 340B program are reimbursed at the wholesale acquisition cost (WAC) plus six percent. For CY 2019 and beyond, CMS will reimburse for these drugs at the WAC plus three percent. This reduced rate applies only during the period of time when ASP data for the new drug is unavailable.

Radiologists Assistants:

CMS finalizes its proposal to allow registered radiologist assistants and radiology practitioner assistants to perform diagnostic tests under direct supervision. Previously the requirement was for personal supervision. Registered radiologist assistants still must comply with applicable state laws and scope of practice regulations.

Therapy Services:

Consistent the BiBA of 2018, CMS establishes two payment modifiers to identify services furnished by physical therapy assistants and occupational therapy assistants. CMS also determines that a service will be considered to have been provided in part by a therapy or occupation therapy assistant when more than 10 percent of the service is provided by such a clinician.

Appropriate-Use Criteria (AUC) for Advanced Diagnostic Imaging:

CMS finalized several proposals related to the AUC program, including:

- Adding independent diagnostic testing facilities to list of applicable settings;
- Allowing auxiliary personnel incident to the order professional's services to perform the required AUC consultation with a clinical decision support mechanism;
- Clarifying that AUC consultation information must be reported on all relevant claims from both furnishing professionals and facilities;
- Establishing a coding methodology to report required AUC information on Medicare claims; and
- Finalizing criteria for meeting hardship exceptions.

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Clinical Laboratory Fee Schedule:

CMS amends the definition of applicable laboratory to include hospital laboratories that bill Medicare for their non-patient laboratory services on the CMS 1450 14X Type of Bill (TOB). As a result, all hospital outreach laboratories will be required to report their private payer rate and volume data to CMS, unless their receive less than $12,500 in CLFS revenues on the 14X TOB during the upcoming data collection period.