Issue Brief

FEDERAL ISSUE BRIEF • July 16, 2018

CMS Proposes CY 2019 Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B; Medicare Shared Savings Program Requirements; and the Quality Payment Program

The Centers for Medicare & Medicaid Services issued a proposed rule that includes proposals to update payment policies, payment rates and quality provisions for services furnished under the Medicare Physician Fee Schedule on or after Jan. 1, 2019.

A copy of the 1,473-page document is available on the ***Federal Register*** website at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf. The rule is scheduled for publication on Friday, July 27. A 60-day comment period ends Monday, Sept. 10.

The PFS Addenda, along with other supporting documents and tables referenced in the proposed rule, are available on the CMS website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html. The link on the left side of the screen titled, "PFS Federal Regulations Notices" includes a chronological list of PFS ***Federal Register*** and other related documents. For the CY 2019 PFS Proposed Rule, refer to item CMS-1693-P.

COMMENT

This proposal is a long and complex document. In fact, it may be the longest proposed rule regarding physician services since Medicare was enacted. The shear length of the rule appears to fly against an administration that says it is committed to reducing regulatory burdens and requirements.

The Medicare Act (the Social Security Amendments of 1965) (Public Law 89-97) that created the program is a mere 138 pages. Something is amiss when it takes nearly 1,500 pages for an annual update to the program.

The table of contents is incomplete. A two-page table of contents for a 1,473-page rule is insufficient to help the reader. While the table contains major heads, it does not identify subheads. Considering the extent of the material, this makes finding items that much more difficult. In the past, we

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have suggested that CMS not only have a complete table of contents, but also provide page numbering. It's not hard to do – it just takes accountability and a little effort.

The rule continues to provide much history. This just compounds the size of information. An update should simply say what is being changed from this year to next year. To address items from five, 10 and even 20 years ago is not material. It just adds confusion.

The rule devotes too much time explaining changes being considered to components and coding items, many of which are not being adopted. What readers want to know is what changes are being proposed from current rates to those for CY 2019.

The proposal includes discussions and proposals regarding the following.

- Potentially Misvalued Codes
- Communication Technology-Based Services
- Valuation of New, Revised and Misvalued Codes
- Payment Rates under the PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital
- E/M Visits
- Therapy Services
- Clinical Laboratory Fee Schedule
- Ambulance Fee Schedule – Provisions in the Bipartisan Budget Act of 2018
- Appropriate Use Criteria for Advanced Diagnostic Imaging Services
- Medicaid Promoting Interoperability Program Requirements for Eligible Professionals
- Medicare Shared Savings Program Quality Measures
- Physician Self-Referral Law
- CY 2019 Updates to the Quality Payment Program
- Request for Information on Promoting Interoperability and Electronic Healthcare Information Exchange through Possible Revisions to the CMS Patient Health and Safety Requirements for Hospitals and Other Medicare- and Medicaid-Participating Providers and Suppliers
- Request for Information on Price Transparency: Improving Beneficiary Access to Provider and Supplier Charge Information

Note: The material that follows does not reflect all of the items above. Page numbers in red identify the start of the items under discussion.

PROPOSED PAYMENT UPDATES AND CONVERSION FACTORS (PAGE 1022)

Section 101(a) of the ***Medicare Access and CHIP Reauthorization Act of 2015*** repealed the previous statutory update formula and amended section 1848(d) of the act to specify the update adjustment factors for calendar years 2015 and beyond. The update adjustment factor for CY 2019, as required by section 53106 of the ***Bipartisan Budget Act of 2018***, is 0.25 percent before applying other adjustments.

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Calculation of the Proposed CY 2019 PFS Conversion Factor		
CY 2018 Conversion Factor		**35.9996**
Statutory Update Factor	0.25 percent (1.0025)	
CY 2019 RVU Budget Neutrality Adjustment	-0.12 percent (0.9988)	
CY 2019 Conversion Factor		36.0463

Calculation of the Proposed CY 2019 Anesthesia Conversion Factor		
CY 2018 National Average Anesthesia Conversion Factor		**22.1887**
Statutory Update Factor	0.25 percent (1.0025)	
CY 2019 RVU Budget Neutrality Adjustment	-0.12 percent (0.9988)	
CY 2019 Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment	+0.365 percent (1.00365)	
CY 2019 Conversion Factor		**22.2986**

I. MAJOR PROVISIONS OF THE RULE FOR PFS

A. Evaluation and Management (E/M) Visits (Page 323)

CMS is proposing several changes to E/M visit documentation and payment. The proposed changes would only apply to office/outpatient visit codes (CPT codes 99201 through 99215), except where CMS specifies otherwise.

CMS proposes:

- to allow practitioners to choose to document office/outpatient E/M visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework;
- to expand current options by allowing practitioners to use time as the governing factor in selecting visit level and documenting the E/M visit, regardless of whether counseling or care coordination dominate the visit;
- to expand current options regarding the documentation of history and exam, to allow practitioners to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information; and
- to allow practitioners to simply review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.

CMS is soliciting comment on how documentation guidelines for medical decision-making might be changed in subsequent years.

Medicare pays for E/M visits furnished in the home (a private residence) under CPT codes 99341 through 99350. CMS proposes to eliminate the requirement to justify the medical necessity of a home visit in lieu of an office visit.

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CMS is soliciting public comment on potentially eliminating a policy that prevents payment for same-day E/M visits by multiple practitioners in the same specialty within a group practice.

For E/M visits furnished by teaching physicians, CMS proposes to eliminate potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team.

New Blended Payments

In conjunction with the proposal to reduce the documentation requirements for E/M visit levels 2 through 5, CMS is proposing to simplify the payment for those services by paying a single rate for the level 2 through 5 E/M visits.

CMS says it would not be material to Medicare's payment decision which CPT code (of levels 2 through 5) is reported on the claim, except to justify billing a level 2 or higher visit in comparison to a level 1 visit (provided the visit itself was reasonable and necessary).

CMS is proposing to maintain the current code set. Of the five levels of office-based and outpatient E/M visits, the vast majority of visits are reported as levels 3 and 4. In CY 2016, CPT codes 99203 and 99204 (or E/M visit level 3 and level 4 for new patients) made up around 32 percent and 44 percent, respectively, of the total allowed charges for CPT codes 99201-99205.

The tables below reflect the payment rates in dollars that would result from this approach were it to have been implemented for CY 2018.

Preliminary Comparison of Payment Rates for Office Visits New Patients

HCPCS Code	CY 2018 Non-facility Payment Rate	CY 2018 Non-facility Payment Rate under the proposed Methodology
99201	$45	$44
99202	$76	$135
99203	$110	
99204	$167	
99205	$211	

Preliminary Comparison of Payment Rates for Office Visits Established Patients

HCPCS Code	Current Non-facility Payment Rate	Proposed Non-facility Payment Rate
99211	$22	$24
99212	$45	$93
99213	$74	
99214	$109	
99215	$148	

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Proposed RVUs for CY 2019 appear in addendum B of the proposed rule, available on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

CMS is proposing the following adjustments "to better capture the variety of resource costs associated with different types of care provided in E/M visits."

- an E/M multiple procedure payment adjustment to account for duplicative resource costs when E/M visits and procedures with global periods are furnished together
- creating a HCPCS G-code for primary care services, (visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (add-on code, list separately in addition to an established patient evaluation and management visit)) – this code would be GPC1X with a work RVU of 0.07 or $2.52
- creating a new HCPCS code GCG0X (visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology or interventional pain management-centered care (add-on code, list separately in addition to an evaluation and management visit)) – this add-on would result in a proposed work RVU of 0.25, or approximately $9.02 (0.25 X CF of $36.0463)
- creating two HCPCS G-codes, HCPCS codes GPD0X (podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, new patient) and GPD1X (podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, established patient), to describe podiatric E/M services – the GPDOX would have an RVU of 1.35, or $48.66, while GPD1X would be 0.85, or $30.64
- creating a single PE/HR value for E/M visits (including all of the proposed HCPCS G-codes discussed above) of approximately $136, based on an average of the PE/HR across all specialties that bill these E/M codes, weighted by the volume of those specialties' allowed E/M services.

The proposal's tables 21, 22 and 23 (page 363) show the estimated changes for certain physician specialties, and isolated from other proposed changes, in expenditures for PFS services based on potential changes for E/M coding and payment.

CMS proposes that these proposed E/M visit policies would be effective Jan. 1, 2019. However, CMS says it is "sensitive to commenters' suggestions that we should consider a multi-year process and proceed cautiously, allowing adequate time to educate practitioners and their staff; and to transition clinical workflows, EHR templates, institutional processes and policies (such as those for provider-based practitioners), and other aspects of practitioner work that would be impacted by these policy changes."

B. Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services (Page 63)

For CY 2019, CMS says it is aiming to increase access for Medicare beneficiaries to physicians' services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology.

1. Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCI1)

CMS is proposing to pay separately, beginning Jan. 1, 2019, for a newly defined type of physicians' service furnished using communication technology. This service would be billable when a physician or other qualified health care professional has a brief non-face-to-face check-in with a patient via communication technology, to assess whether the patient's condition necessitates an office visit. The proposed code would be described as GVCI1 (brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous seven days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; five to 10 minutes of medical discussion). CPT code GVCI1 would have a work RVU of 0.25, or $9.02.

2. Remote Evaluation of Prerecorded Patient Information (HCPCS code GRAS1)

CMS is proposing to create specific coding that describes the remote professional evaluation of patient-transmitted information conducted via prerecorded "store and forward" video or image technology. These services would not be subject to the Medicare telehealth restrictions in section 1834(m) of the act, and the valuation would reflect the resource costs associated with furnishing services utilizing communication technology. CPT code GRAS1 would have a work RVU of 0.18, or $6.56.

3. Inter-professional Internet Consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448 and 99449)

CMS also is proposing to pay separately for new coding describing Chronic Care Remote Physiologic Monitoring (CPT codes 990X0, 990X1 and 994X9) and Inter-professional Internet Consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448 and 99449).

C. Medicare Telehealth Services (Page 76)

CMS is proposing to add the following services to the telehealth list on a Category 1 basis for CY 2019.

- HCPCS codes G0513 and G0514 (prolonged preventive service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first 30 minutes (list separately in addition to code for preventive service) and (prolonged preventive service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual

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service; each additional 30 minutes (list separately in addition to code G0513 for additional 30 minutes of preventive service). The work RVUs for G0513 and G0514 would both be 1.17, or $42.17 (1.17 X CF $36.0463).

CMS also is proposing to implement the requirements of the **Bipartisan Budget Act of 2018** for telehealth services related to beneficiaries with end-stage renal disease receiving home dialysis and beneficiaries with acute stroke effective Jan. 1, 2019. CMS proposes to add renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities and beneficiary homes, for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments. CMS proposes to add mobile stroke units as originating sites and not to apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation or treatment of symptoms of an acute stroke.

D. Determination of Practice Expense Relative Value Units (Page 15)

Practice expense is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding malpractice expenses.

This material, extending some 45 pages, provides technical and detailed information about the methodology, inputs and resources involved in transforming each service into service-specific PE RVU.

The proposed direct PE inputs for CY 2019 are displayed in the CY 2019 direct PE input database, available on the CMS website under the downloads for the CY 2019 PFS proposed rule at: http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html.

E. Determination of Malpractice Relative Value Units (Page 60)

For CY 2019, CMS does not appear to be changing its methodology to determine the Malpractice RVUs.
However, CMS is seeking additional comments regarding the next MP RVU update, which must occur by CY 2020.

Specifically, CMS is seeking comments on how it might improve the way that specialties in the state-level raw rate filings data are crosswalked for categorization into CMS specialty codes, which are used to develop the specialty-level risk factors and the MP RVUs.

F. Radiologist Assistants (Page 113)

CMS is proposing to revise the physician supervision requirements so that any diagnostic test performed by a Radiologist Assistant may be furnished under, at most, a direct level of physician supervision, when performed by an RA in accordance with state law and state scope of practice rules. This is in response to stakeholder comments that the current requirement of personal supervision that applies to some diagnostic tests is overly restrictive when the test is performed by an RA, and does not allow radiologists to make full use of RAs, and that reducing the required level of supervision will improve efficiency of care.

G. Payment Rates under the Medicare PFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of a Hospital (Page 115)

Section 603 of the ***Bipartisan Budget Act of 2015*** requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the Hospital Outpatient Prospective Payment System and are instead paid the PFS for most of these items and services.

Since CY 2017, payment for these items and services has been made under the PFS using a PFS relativity adjuster based on a percentage of the OPPS payment rate. The PFS relativity adjuster in CY 2018 is 40 percent, meaning that nonexcepted items and services are paid 40 percent of the amount that would have been paid for those services under the OPPS.

For CY 2019, CMS is proposing to maintain the current PFS Relatively Adjuster at 40 percent. CMS believes that this PFS Relatively Adjuster encourages fairer competition between hospitals and physician practices by promoting greater payment alignment between outpatient care settings.

Also for CY 2019, CMS proposes to continue to identify the PFS as the applicable payment system for partial hospitalization programs furnished by nonexcepted off-campus PBDs, and proposes to continue to set the PFS payment rate for these PHP services as the per diem rate that would be paid to a community mental health center in CY 2019.

H. Valuation of Specific Codes (Page 130)

CMS reviews the resource inputs for several hundred codes under the annual process referred to as the potentially misvalued code initiative. CMS says recommendations from the American Medical Association-Relative Value Scale Update Committee (RUC) are critically important to this work.

CMS explains changes it is making, and in many cases not making, to the specific codes identified below. The material in this section covers nearly 200 pages. The table below identifies specific codes that CMS has reviewed in this proposed rule.

In red is the rule's display copy page on which the code(s) discussion begins.

1	Fine Needle Aspiration (CPT codes 10021, 10X11, 10X12, 10X13, 10X14, 10X15, 10X16, 10X17, 10X18, 10X19, 76492, 77002 and 77021) Page 145
2	Biopsy of Nail (CPT code 11755) Page 149
3	Skin Biopsy (CPT codes 11X02, 11X03, 11X04, 11X05, 11X06 and 11X07) Page 151
4	Injection Tendon Origin-Insertion (CPT code 20551) Page 153
5	Structural Allograft (CPT codes 209X3, 209X4 and 209X5) Page 154
6	Knee Arthrography Injection (CPT code 27X69) Page 155
7	Application of Long Arm Splint (CPT code 29105) Page 156
8	Strapping Lower Extremity (CPT codes 29540 and 29550) Page 157
9	Bronchoscopy (CPT codes 31623 and 31624) Page 157
10	Pulmonary Wireless Pressure Sensor Services (CPT codes 332X0 and 93XX1) Page 158
11	Cardiac Event Recorder Procedures (CPT codes 332X5 and 332X6) Page 159
12	Aortoventriculoplasty with Pulmonary Autograft (CPT code 335X1) Page 159
13	Hemi-Aortic Arch Replacement (CPT code 33X01) Page 160
14	Leadless Pacemaker Procedures (CPT codes 33X05 and 33X06) Page 161
15	PICC Line Procedures (CPT codes 36568, 36569, 36X72, 36X73 and 36584) Page 163
16	Biopsy or Excision of Inguinofemoral Node(s) (CPT code 3853X) Page 168
17	Radioactive Tracer (CPT code 38792) Page 169
18	Percutaneous Change of G-Tube (CPT code 43760) Page 170
19	Gastrostomy Tube Replacement (CPT codes 43X63 and 43X64) Page 170
20	Diagnostic Proctosigmoidoscopy – Rigid (CPT code 45300) Page 171
21	Hemorrhoid Injection (CPT code 46500) Page 171
22	Removal of Intraperitoneal Catheter (CPT code 49422) Page 173
23	Dilation of Urinary Tract (CPT codes 50X39, 50X40, 52334 and 74485) Page 174
24	Transurethral Destruction of Prostate Tissue (CPT codes 53850, 53852 and 538X3) Page 178
25	Vaginal Treatments (CPT codes 57150 and 57160) Page 181
26	Biopsy of Uterus Lining (CPT codes 58100 and 58110) Page 181
27	Injection Greater Occipital Nerve (CPT code 64405) Page 182
28	Injection Digital Nerves (CPT code 64455) Page 182
29	Removal of Foreign Body – Eye (CPT codes 65205 and 65210) Page 183
30	Injection – Eye (CPT codes 67500, 67505 and 67515) Page 185
31	X-Ray Spine (CPT codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114 and 72120) Page 187
32	X-Ray Sacrum (CPT codes 72200, 72202 and 72220) Page 191
33	X-Ray Elbow-Forearm (CPT codes 73070, 73080 and 73090) Page 191
34	X-Ray Heel (CPT code 73650) Page 192
35	X-Ray Toe (CPT code 73660) Page 192
36	X-Ray Esophagus (CPT codes 74210, 74220 and 74230) Page 192
37	X-Ray Urinary Tract (CPT code 74420) Page 193
38	Fluoroscopy (CPT code 76000) Page 194
39	Echo Exam of Eye Thickness (CPT code 76514) Page 195
40	Ultrasound Elastography (CPT codes 767X1, 767X2 and 767X3) Page 196
41	Ultrasound Exam – Scrotum (CPT code 76870) Page 197

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42	Contrast-Enhanced Ultrasound (CPT codes 76X0X and 76X1X) Page 198
43	Magnetic Resonance Elastography (CPT code 76X01) Page 200
44	Computed Tomography (CT) Scan for Needle Biopsy (CPT code 77012) Page 202
45	Dual-Energy X-Ray Absorptiometry (CPT code 77081) Page 203
46	Breast MRI with Computer-Aided Detection (CPT codes 77X49, 77X50, 77X51 and 77X52) Page 204
47	Blood Smear Interpretation (CPT code 85060) Page 208
48	Bone Marrow Interpretation (CPT code 85097) Page 209
49	Fibrinolysins Screen (CPT code 85390) Page 211
50	Electroretinography (CPT codes 92X71, 92X73 and 03X0T) Page 211
51	Cardiac Output Measurement (CPT codes 93561 and 93562) Page 216
52	Coronary Flow Reserve Measurement (CPT codes 93571 and 93572) Page 219
53	Peripheral Artery Disease (PAD) Rehabilitation (CPT code 93668) Page 220
54	Home Sleep Apnea Testing (CPT codes 95800, 95801 and 95806) Page 221
55	Neurostimulator Services (CPT codes 95970, 95X83, 95X84, 95X85 and 95X86) Page 223
56	Psychological and Neuropsychological Testing (CPT codes 96105, 96110, 96116, 96125, 96127, 963X0, 963X1, 963X2, 963X3, 963X4, 963X5, 963X6, 963X7, 963X8, 963X9, 96X10, 96X11 and 96X12) Page 232
57	Electrocorticography (CPT code 96X00) Page 236
58	Chronic Care Remote Physiologic Monitoring (CPT codes 990X0, 990X1 and 994X9) Page 236
59	Interprofessional Internet Consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448 and 99449) Page 238
60	Chronic Care Management Services (CPT code 994X7) Page 239
61	Diabetes Management Training (HCPCS codes G0108 and G0109) Page 241
62	External Counterpulsation (HCPCS code G0166) Page 242
63	Wound Closure by Adhesive (HCPCS code G0168) Page 242
64	Removal of Impacted Cerumen (HCPCS code G0268) Page 243
65	Structured Assessment, Brief Intervention, and Referral to Treatment for Substance Use Disorders (HCPCS codes G0396, G0397 and GSBR1) Page 244
66	Prolonged Services (HCPCS code GPRO1) Page 245
67	Remote pre-recorded services (HCPCS code GRAS1) Page 246
68	Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCI1) Page 247
69	Visit Complexity Inherent to Certain Specialist Visits (HCPCS code GCG0X) Page 248
70	Visit Complexity Inherent to Primary Care Services (HCPCS code GPC1X) Page 249
71	Podiatric Evaluation and Management Services (HCPCS codes GPD0X and GPD1X) Page 250
72	Comment Solicitation on Superficial Radiation Treatment Planning and Management Page 250

The rule's table 13 contains the CPT code descriptors for all proposed, new, revised and potentially misvalued codes discussed in this section. (Pages 255-274) Table 14 contains CY 2019 Proposed Direct PE Refinements. (Pages 275-318)

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I. Solicitation of Public Comments on the Low Expenditure Threshold Component of the Applicable Laboratory Definition under the Medicare Clinical Laboratory Fee Schedule (CLFS) (Page 378)

CMS is soliciting public comments on an approach that would increase the low expenditure threshold by 50 percent, from $12,500 to $18,750, in CLFS revenues received in a data collection period.

J. Therapy Services (Page 382)

1. Repeal of the Therapy Caps and Limitation to Ensure Appropriate Therapy

Section 50202 of the ***Bipartisan Budget Act of 2018*** amended section 1833(g) of the act, effective Jan. 1, 2018, to repeal the application of the Medicare outpatient therapy caps and the therapy cap exceptions process while retaining and adding limitations to ensure therapy services are furnished when appropriate.

Section 50202 also adds section 1833(g)(7)(A) of the act to require that after expenses incurred for the beneficiary's outpatient therapy services for the year have exceeded one or both of the previous therapy cap amounts, all therapy suppliers and providers must continue to use an appropriate modifier, such as the KX modifier, on claims for subsequent services for Medicare to pay for the services.

For CY 2018, this KX modifier threshold amount is $2,010 for PT and SLP services combined, and $2,010 for OT.

2. Proposed Payment for Outpatient PT and OT Services Furnished by Therapy Assistants

The ***Bipartisan Budget Act of 2018*** requires payment for services furnished in whole or in part by a therapy assistant at 85 percent of the applicable Part B payment amount for the service effective Jan. 1, 2022. In order to implement this payment reduction, the law requires CMS to establish a new modifier by Jan. 1, 2019.

CMS is proposing to define the new therapy modifiers for services furnished in whole or in part by therapy assistants and to revise the existing therapy modifier descriptors as follows.

- new -PT Assistant services modifier (to be used instead of the GP modifier currently reported when a PTA furnishes services in whole or in part): services furnished in whole or in part by a physical therapist assistant under an outpatient physical therapy plan of care
- new -OT Assistant services modifier (to be used instead of the GO modifier currently reported when an OTA furnishes services in whole or in part): services furnished in whole or in part by occupational therapy assistant under an outpatient occupational therapy plan of care

CMS is proposing that the existing GP modifier "Services delivered under an outpatient physical therapy plan of care" be revised to read as follows.

- revised GP modifier: services fully furnished by a physical therapist or by or incident to the services of another qualified clinician – that is, physician, nurse practitioner, certified clinical nurse specialist or physician assistant – under an outpatient physical therapy plan of care

CMS is proposing that the existing GO modifier "Services delivered under an outpatient occupational therapy plan of care" be revised to read as follows.

- revised GO modifier: services fully furnished by an occupational

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therapist or by or incident to the services of another qualified clinician – that is, physician, nurse practitioner, certified clinical nurse specialist or physician assistant – under an outpatient occupational therapy plan of care

CMS is proposing that the existing GN modifier that currently reads "Services delivered under an outpatient speech-language pathology plan of care" be revised to be consistent with the revisions to the GP and GO modifiers to read as follows.

- revised GN modifier: services fully furnished by a speech-language pathologist or by or incident to the services of another qualified clinician – that is, physician, nurse practitioner, certified clinical nurse specialist or physician assistant – under an outpatient speech-language pathology plan of care

L. Part B Drugs: Application of an Add-on Percentage for Certain Wholesale Acquisition Cost-based Payments (Page 396)

CMS is proposing that effective Jan. 1, 2019, Wholesale Acquisition Cost-based payments for Part B drugs made under section 1847A(c)(4) of the act, utilize a 3.0 percent add-on in place of the 6.0 percent add-on that is currently being used.

II. OTHER PROVISIONS OF THE PROPOSED RULE

A. Clinical Laboratory Fee Schedule (Page 402)

Beginning Jan. 1, 2018, the payment amount for a test on the CLFS is generally equal to the weighted median of private payer rates determined for the test, based on the data of "applicable laboratories" that is collected during a specified data collection period and reported to CMS during a specified data reporting period. The first data collection period was Jan. 1 through June 30, 2016, and the first data reporting period was from Jan. 1 through March 31, 2017.

CMS is proposing a change to the way Medicare Advantage payments are treated in its definition of "applicable laboratory." If CMS were to finalize the proposed change, additional laboratories of all types serving a significant population of beneficiaries enrolled in Medicare Part C could meet the majority of Medicare revenues threshold and potentially qualify as an applicable laboratory and report data to CMS.

CMS is seeking public comments on alternative approaches for defining an applicable laboratory, for example, using the Form CMS 1450 14x bill type or CLIA certificate number to define an applicable laboratory. CMS also is seeking public comments on potential changes to the low expenditure threshold component of the definition of an applicable laboratory.

B. Proposed Changes to the Regulations Associated with the Ambulance Fee Schedule (Page 425)

The ***Bipartisan Budget Act of 2018*** extended the temporary add-on payments for ground ambulance services for five years. The three temporary add-on payments include: (1) a 3.0 percent increase to the base and mileage rate for ground ambulance transports that originate in rural areas; (2) a 2.0 percent increase to the base and mileage rate for ground ambulance transports that originate in urban areas; and (3) a 22.6 percent increase in the base rate for ground ambulance transports that originate in super rural areas. These provisions were set to

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expire on Dec. 31, 2017, but have been extended through Dec. 31, 2022. The ***Bipartisan Budget Act*** also increased the reduction from 10 percent to 23 percent in payments for nonemergency basic life support transports of beneficiaries with ESRD for renal dialysis services. This provision is effective with services on or after Oct. 1, 2018. CMS is proposing to revise regulations to conform with these requirements

C. Rural Health Clinics and Federally Qualified Health Centers (Page 431)

CMS is proposing for CY 2019 a new CPT code, 994X7, which would correspond to 30 minutes or more of Chronic Care Management furnished by a physician or other qualified health care professional and is similar to CPT codes 99490 and 99487. For rural health clinics and federally qualified health centers, CMS is proposing to add CPT code 994X7 as a general care management service and to include it in the calculation of HCPCS code G0511. That is, CMS proposes that starting on Jan. 1, 2019, RHCs and FQHC would be paid for G0511 based on the average of the national nonfacility PFS payment rates for CPT codes 99490, 99487, 99484 and 994X7.

CMS is proposing for CY 2019 separate payment for certain communication technology-based services. This includes what is referred to as "Brief Communication Technology-based Service" for a "virtual check-in" and separate payment for remote evaluation of recorded video and/or images.

These services would be payable for medical discussions or remote evaluations of conditions not related to an RHC or FQHC service provided within the previous seven days or within the next 24 hours or at the soonest available appointment. RHCs and FQHCs would be able to bill a newly created RHC/FQHC Virtual Communications G-code, with payment set at the average of the PFS national nonfacility payment rates for communication technology-based services and remote evaluation services.

D. Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Services (Page 438)

Section 1834(q) of the act includes rapid timelines for establishing a Medicare AUC program for advanced diagnostic imaging services. The impact of this program is extensive, as it will apply to every physician or other practitioner who orders or furnishes advanced diagnostic imaging services (for example, MRI, CT or PET).

CMS is proposing policies to modify existing requirements and criteria and to provide further clarification on implementation of the AUC program. Also, CMS proposes to revise the significant hardship criteria in the AUC program to include: (1) insufficient internet access; (2) electronic health record or clinical decision support mechanism vendor issues; or (3) extreme and uncontrollable circumstances. In addition, CMS is proposing to add independent diagnostic testing facilities (IDTFs) to the definition of applicable setting under this program. This will allow the AUC program to be more consistently applied to outpatient settings. CMS also is proposing to allow AUC consultations, when not personally performed by the ordering professional, to be performed by auxiliary personnel. This will allow the ordering professional to exercise their discretion to delegate the performance of this consultation.

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E. Medicare Shared Savings Program (Page 471)

CMS is proposing the following changes to the quality performance measures that will be used to assess quality performance under the Shared Savings Program for performance year 2019 and subsequent years.

- changes to Patient Experience of Care Survey measures
- changes to CMS Web Interface and Claims-Based measures

CMS is proposing to begin scoring two Summary Survey Measures that are currently collected with the administration of the CAHPS for ACOs survey and shared with the ACOs for informational purposes only. Under this proposal, CMS would add the following CAHPS for ACOs SSMs that already are collected and provided to ACOs for informational purposes to the quality measure set for the Shared Savings Program as ACO-45, CAHPS: Courteous and Helpful Office Staff, and ACO-46, CAHPS: Care Coordination. These measures would be scored and included in the ACO quality determination beginning in 2019. Both of these SSMs are currently designated by AHRQ as CG CAHPS core measures.

Further, CMS is proposing to reduce the total number of measures in the Shared Savings Program quality measure set.

CMS is proposing to eliminate 10 measures and to add one measure to the Shared Savings Program quality measure set. The following would be eliminated.

- ACO-35 Skilled Nursing Facility 30-Day All-Cause Readmission Measure
- ACO-36 All-Cause Unplanned Admissions for Patients with Diabetes
- ACO-37 All-Cause Unplanned Admission for Patients with Heart Failure
- ACO-12 (NQF #0097) Medication Reconciliation Post-Discharge
- ACO-13 (NQF #0101) Falls: Screening for Future Fall Risk
- ACO-15 (NQF #0043) Pneumonia Vaccination Status for Older Adults
- ACO-16 (NQF #0421) Preventive Care and Screening: Body Mass Index Screening and Follow Up
- ACO-41 (NQF #0055) Diabetes: Eye Exam
- ACO-30 (NQF #0068) Ischemic Vascular Disease: Use of Aspirin or another Antithrombotic
- ACO-44 Use of Imaging Studies for Low Back Pain

The rule's Tables 25 and 26 provide additional information on measures. (Page 485)

CMS is proposing to add the following measure to the CMS web interface for purposes of the Quality Payment Program.

- ACO-47 (NQF #0101) Falls: Screening, Risk-Assessment and Plan of Care to Prevent

Future Falls.

F. CY 2019 Updates to the Quality Payment Program (Page 493)

CMS says, "The Medicare Access and CHIP Reauthorization Act of 2015 amended title XVIII of the act to repeal the Medicare sustainable growth rate formula to reauthorize the Children's Health Insurance Program and to strengthen Medicare access by improving physician and other clinician payments and making other improvements. MACRA advances a forward-looking, coordinated framework for clinicians

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to successfully take part in the Quality Payment Program that rewards value in one of two ways:

- the Merit-based Incentive Payment System
- Advanced Alternative Payment Models"

For the 2019 MIPS performance period, CMS is proposing the following updates: (1) adding 10 new MIPS quality measures that include four patient reported outcome measures, seven high priority measures, one measure that replaces an existing measure, and two other measures on important clinical topics in the Meaningful Measures framework; and (2) removing 34 quality measures.

COMMENT

The quality preamble section of this proposed rule extends more than 400 pages. In addition, Appendix 1 (Page 1197) contains the following tables.

- Table A: Proposed New Quality Measures for Inclusion in MIPS for the 2021 MIPS Payment Year and Future Years (Page 1197)
- Table B: Proposed New and Modified MIPS Specialty Measure Sets for the 2021 MIPS Payment Year and Future Years (Page 1208)
- Table C: Quality Measures Proposed for Removal in the 2021 MIPS Payment Year and Future Years (Page 1420)
- Table D: Measures with Substantive Changes Proposed for the 2021 MIPS Payment Year and Future Years (Page 1441)

The discussion of quality is nearly 700 pages. CMS has provided a half page summary of the quality items. On July 13, CMS augmented its summary of the quality implications with the following.

Key proposals for Year 3 of the Quality Payment Program include the following.

- expanding the definition of Merit-based Incentive Payment System eligible clinicians to include new clinician types (physical therapists, occupational therapists, clinical social workers and clinical psychologists)
- adding a third element (Number of Covered Professional Services) to the low-volume threshold determination and providing an opt-in policy that offers eligible clinicians who meet or exceed one or two, but not all, elements of the low-volume threshold the ability to participate in MIPS
- providing the option to use facility-based scoring for facility-based clinicians that doesn't require data submission
- modifying the MIPS Promoting Interoperability (formerly Advancing Care Information) performance category to support greater electronic health record interoperability and patient access while aligning with the proposed new Promoting Interoperability Program requirements for hospitals
- moving clinicians to a smaller set of objectives and measures with scoring based on performance for the Promoting Interoperability performance category
- continuing the small practice bonus, but including it in the quality performance category score of clinicians in small practices instead of as a standalone bonus
- streamlining the definition of a MIPS comparable measure in both the Advanced Alternative Payment Models criteria and Other Payer

Advanced APM criteria to reduce confusion and burden amongst payers and eligible clinicians submitting payment arrangement information to CMS

- updating the MIPS APM measure sets that apply for purposes of the APM scoring standard
- increasing flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program
- updating the Advanced APM Certified EHR Technology threshold so that an Advanced APM must require that at least 75 percent of eligible clinicians in each APM Entity use CEHRT
- extending the 8 percent revenue-based nominal amount standard for Advanced APMs through performance year 2024

Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

FINAL THOUGHTS

The quality material is simply overwhelming, complex and exhaustive. Those engaged in this activity need to carefully review the material to insure compliance. This is not a simple task.

In reviewing the extensive regulatory analysis section, it does not appear that CMS has identified any overall change in CY 2019 physician payments. CMS does say "that the PFS provisions included in this proposed rule would redistribute more than $100 million in one year." No doubt, the redistribution is from the proposed changes in E/M payments.

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