

## ALERT

### AAWC's Voice Has Been Heard! The CMS Issued the Medicare Final Rule for the Physician Fee Schedule

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**AAWC's Voice Has Been Heard!** The CMS has removed or revised issues in the proposed rule that the AAWC submitted to CMS as detrimental for Physicians, Podiatrists, other Qualified Healthcare Professionals as well as patients. In response to concerns raised on the proposed rule, the final rule includes revisions that preserve access to care for complex patients, equalize certain payments for primary and specialty care, and allow for continued stakeholder engagement by delaying implementation of E/M coding reforms until 2021.

#### Conversion Factor

With the budget neutrality adjustment to account for changes in RVUs, all required by law, the final 2019 PFS conversion factor is **\$36.04**, a slight increase above the 2018 PFS conversion factor of \$35.99.

#### Key Provisions:

1. Did not establish separate coding and payment for podiatric E/M visits
2. Maintained the current **coding and payment structure** for E/M office/outpatient visits until 2021
3. Did not reduced payment when E/M office/outpatient visits are furnished on the same day as procedures
4. Discontinued the functional status reporting requirements for therapy services furnished on or after January 1, 2019.
5. Implemented new documentation policies for CYs 2019 and 2020 to provide immediate relief from excessive paperwork to address provider burnout
6. Streamlined quality measures to reduce burden and encourage better health outcomes
7. Changed EHR information exchange requirements to improve interoperability
8. Reduced payment method for new Part B drugs
9. Delayed the proposed single payment for consolidation of E/M Levels until 2021 and changed from Levels 2-5 service codes to only levels 2-4.
10. Revised physician supervision requirements for diagnostic tests performed by a Radiologist Assistant (RA) that meets certain requirements
11. Paying separately for two new **defined physicians' services** of virtual care using communication technology:
  - a. **HCPCS code G2012**: Brief communication technology-based service, e.g. virtual check-in
  - b. **HCPCS code G2010**: Remote evaluation of recorded video and/or images submitted by an established patient
12. Establishing separate payment for new codes describing chronic care remote physiologic monitoring (**CPT codes 99453, 99454, and 99457**) and interprofessional internet consultation (**CPT codes 99451, 99452, 99446, 99447, 99448, and 99449**).
13. Expanded list of telehealth services to included HCPCS codes **G0513 and G0514** for prolonged preventive service(s)

14. Changed add-on percentage for WAC-based payments of new Part B drugs, during the first quarter of sales when ASP is unavailable, from 6% to a **3%**
15. Updating direct PE input prices for supplies and equipment
16. Establishing two new modifiers [Physical Therapy Assistants (PTA)] & [Occupational Therapy Assistants (OTA)] – when services are furnished in whole, or in part by a PTA or OTA.

#### **Payment & Documentation - CY 2019 and CY 2020:**

CMS will continue the **current coding and payment structure** for E/M office/outpatient visits, and Practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare.

**CY 2019 and beyond** - CMS is finalizing the following policies:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners **may choose** to focus their documentation on what has changed since the last visit, **or on pertinent items that have not changed**, and **do not have to re-record the defined list of required elements** if there is evidence that the practitioner reviewed the previous information and updated it as needed.
  - Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;
- For E/M office/outpatient visits for new and established patients, practitioners need not re-enter in the medical record information on the **patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary**.
  - Practitioners may simply indicate in the medical record that he/ she reviewed and verified this information; and
  - Removal of 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 for E/M visits furnished by teaching physicians.

#### **Beginning CY 2021:**

Payment for E/M office/outpatient visits will be simplified and payment would vary primarily based on attributes that do not require separate, complex documentation. CMS is finalizing the following policies:

- Reduction in the payment variation for E/M office/outpatient visit levels by paying a **single rate for E/M office/outpatient visit levels 2 through 4** for established and new patients
- Maintain payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;

- Permit practitioners to choose to document E/M office/outpatient level 2 through 5 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;
- E/M office/outpatient levels 2 through 5 visits, allow for flexibility in how visit levels are documented— specifically a choice to use the current framework, MDM, or time.
  - For E/M office/outpatient level 2 through 4 visits, when using MDM or current framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or medical decision-making;
  - When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner **personally spent the required amount of time face-to-face** with the beneficiary;
- Implement ‘**add-on**’ codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would **not be restricted by physician specialty**.
  - These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements; and
- Adopt a **new “extended visit” add-on code** for use only with E/M office/outpatient **level 2 through 4 visits** to account for the additional resources required when practitioners need to spend extended time with the patient.

Final policies for Year 3 of the QPP, part of the agency’s implementation of MACRA, will advance the Meaningful Measures initiative while reducing clinician burden, ensuring a focus on outcomes, and promoting interoperability. CMS also introduced an opt-in policy so that certain clinicians who see a low volume of Medicare patients can still participate in the Merit-based Incentive Payment System program if they choose to do so. In addition, CMS is providing the option for clinicians who are based at a health care facility to use facility-based scoring to reduce the burden of having to report separately from their facility.

## Other Components

### Outpatient Physical Therapy and Occupational Therapy 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% of the applicable Part B payment** amount for the service effective **January 1, 2022**. In order to implement this payment reduction, the law requires us to establish a new modifier by January 1, 2019.

CMS is finalizing our proposal to establish two new modifiers – one for Physical Therapy Assistants (PTA) and another for Occupational Therapy Assistants (OTA) – when services are furnished in whole, or in part by a PTA or OTA. However, CMS is finalizing the new modifiers as **“payment” rather than as “therapy” modifiers**, based on comments from stakeholders. These will be used alongside of the current PT and OT modifiers, instead of replacing them, which retains the use of the three existing therapy modifiers to report all PT, OT, and Speech Language Pathology services, that have been used since 1998 to track outpatient therapy services that were subject to the therapy caps. CMS is also finalizing a de minimis standard under which a service is furnished in whole or in part by a PTA or OTA when more than 10 percent of the service is furnished by the PTA or OTA, instead of the proposed definition that applied when a PTA or OTA furnished any minute of a therapeutic service. The new therapy modifiers for services furnished by PTAs and OTAs are not required on claims until January 1, 2020.

### **Payment Rates for Non-excepted Off-campus Provider-Based Hospital Departments Paid Under the PFS**

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 (OPPS) and are instead paid under the applicable payment system. In CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.

Since CY 2017, payment for these items and services furnished in non-excepted off-campus provider-based departments 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 non-excepted items and services are paid 40 percent of the amount that would have been paid for those services under the OPPS. CMS is finalizing that the PFS Relativity Adjuster remain at 40 percent for CY 2019. CMS believes that this PFS Relativity Adjuster encourages fairer competition between hospitals and physician practices by promoting greater payment alignment between outpatient care settings.

### **Medicare Telehealth Services for ESRD**

CMS is also finalizing policies to implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with end-stage renal disease (ESRD) receiving home dialysis and beneficiaries with acute stroke effective January 1, 2019.

CMS is finalizing the addition of 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 is also finalizing policies to add mobile stroke units as originating sites and to not apply originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

## **Clinical Laboratory Fee Schedule**

The Clinical Laboratory Fee Schedule (CLFS) final rule entitled “Medicare Program: Medicare Clinical Diagnostic Laboratory Tests Payment System” implemented Section 1834A of the Social Security Act (the Act), which required extensive revisions to the Medicare payment, coding, and coverage for clinical diagnostic laboratory tests (CDLTs) paid under the CLFS. Beginning January 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 from January 1 through June 30, 2016, and the first data reporting period was from January 1, 2017, through March 31, 2017, including an additional 60-day enforcement discretion period.

In determining payment rates under the private payer rate-based CLFS, one of our goals is to obtain as much applicable information as possible from the broadest possible representation of the national laboratory market on which to base CLFS payment amounts without imposing undue burden on those entities. In the interest of facilitating this goal, CMS proposed a change to the way Medicare Advantage payments are treated in our definition of “applicable laboratory.” CMS is finalizing this proposal, which we believe may result in additional laboratories of all types that serve a significant population of beneficiaries enrolled in Medicare Part C in meeting the majority of Medicare revenues threshold and potentially qualifying as an applicable laboratory and report data to CMS.

In addition, CMS sought public comments on alternative approaches for defining an applicable laboratory, for example, using the Form CMS 1450 14X Type of Bill (TOB) or CLIA certificate number to define an applicable laboratory. Based on comments we received and further analysis of the various options, we are amending the applicable laboratory definition to include hospital laboratories that bill for their non-patient laboratory services on the CMS 1450 14X TOB bill. CMS also sought public comments on potential changes to the low expenditure threshold component of the definition of an applicable laboratory, and will consider those comments as we continue to evaluate and refine Medicare CLFS payment policy in the future.

## **Ambulance Fee Schedule Payments**

The Bipartisan Budget Act of 2018 extended the temporary add-on payments for ground ambulance services for 5 years. The three temporary add-on payments include: (1) a 3 percent increase to the base and mileage rate for ground ambulance transports that originate in rural areas; (2) a 2 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 expire on December 31, 2017, but have been extended through December 31, 2022. The Bipartisan Budget Act also increased the payment reduction from 10 percent to 23 percent for non-emergency basic life support transports of beneficiaries with end-stage renal disease for renal dialysis services furnished other than on an emergency basis by a provider of services or a renal dialysis facility. This provision is effective with ambulance services furnished on or after October 1, 2018. CMS has revised the applicable regulations to conform with these requirements.

## **Recognizing Communication Technology-Based and Remote Evaluation Services for Rural Health Clinics and Federally Qualified Health Centers**

For CY 2019, CMS finalized payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit. These services will be payable for medical discussions or remote evaluations of conditions not related to an RHC or FQHC service provided within the previous 7 days or within the next 24 hours or at the soonest available appointment. RHCs and FQHCs will be able to bill for these services using a newly created RHC/FQHC Virtual Communication Service HCPCS code, G0071, with payment set at the average of the PFS national non-facility payment rates for communication technology-based services and remote evaluation services.

## **Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs)**

This final rule also addresses a subset of changes to the Medicare Shared Savings Program for ACOs proposed in the August 2018 proposed rule “Medicare Program; Medicare Shared Savings Program; Accountable Care Organizations Pathways to Success” and other revisions designed to update program policies under the Shared Savings Program. In order to ensure continuity of participation, finalize time-sensitive program policy changes for currently participating ACOs, and streamline the ACO core quality measure set to reduce burden and encourage better outcomes, CMS is finalizing the following policies.

- A voluntary 6-month extension for existing ACOs whose participation agreements expire on December 31, 2018, and the methodology for determining financial and quality performance for this 6-month performance year from January 1, 2019, through June 30, 2019.
- Allowing beneficiaries who voluntarily align to a NP, PA, CNS, or a physician with a specialty not used in assignment to be prospectively assigned to an ACO if the clinician they align with is participating in an ACO, as provided for in the Bipartisan Budget Act of 2018.
- Revising the definition of primary care services used in beneficiary assignment.
- Providing relief for ACOs and their clinicians impacted by extreme and uncontrollable circumstances in 2018 and subsequent years.
- Reducing the Shared Savings Program core quality measure set by 8 measures; and promoting interoperability among ACO providers and suppliers by adding a new CEHRT threshold criterion to determine ACOs’ eligibility for program participation and retiring the current Shared Savings Program quality measure on the percentage of eligible clinicians using CEHRT.

## **Request for Information on Price Transparency**

Under current law, hospitals are required to establish and make public a list of their standard charges. In an effort to encourage price transparency by improving the public accessibility of price information, CMS included a Request for Information related to price transparency and improving beneficiary access to provider and supplier charge information in the CY 2019 PFS proposed rule. CMS appreciates the input provided by commenters.

### **Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging**

For CY 2019, CMS is finalizing the revision of the significant hardship criteria in the AUC program to include: 1) insufficient internet access; 2) electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues; or 3) extreme and uncontrollable circumstances. CMS is also finalizing allowing ordering professionals experiencing a significant hardship to self-attest their hardship status. In addition, CMS is adding 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 is also allowing AUC consultations, when not personally performed by the ordering professional, to be performed by clinical staff under the direction of ordering professional. This will allow the ordering professional to exercise their discretion to delegate the performance of this consultation.

### **Expanding Use of Telehealth Services for Treatment of Opioid Use Disorder and Other Substance Use Disorders**

Through an interim final rule with comment period, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished **on or after July 1, 2019**.

The SUPPORT for Patients and Communities Act establishes a new Medicare benefit category for opioid use disorder treatment services furnished by opioid treatment programs (OTP) under Medicare Part B, **beginning on or after January 1, 2020**.

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