**Medicare PFS Final Rule Released: A topline summary from ACG, AGA and ASGE**

On Nov. 1, 2018, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2019 Medicare Physician Fee Schedule (PFS) Final Rule, which includes several significant policy and payment changes that are expected to impact practitioners beginning in CY 2021. Below is a summary of key issues for echocardiography.

**Misvalued Code Initiative:** In an unprecedented move by CMS, the insurer Anthem nominated CPT code 93306 – Transthoracic Echocardiography, Complete - as potentially "misvalued." It is disappointing that CMS accepted Anthem's petition to include 93306 for review under the potentially misvalued code initiative in the Final Rule. The most recent AMA RUC review of CPT code 93306 was published in CY2018, and all inputs were accepted by CMS.

In its [appeal](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2019-PFS-FR-Potentially-Misvalued-Codes.pdf) (attached) to CMS, Anthem stated that it is "apparent" that, in most cases, the new values continue to be "excessive and not empirically supported." It is both alarming and unclear why CMS set this precedent for accepting payor input into the valuation of CPT codes. Commercial payers typically base their payment rates as a percentage of the Medicare fee schedule and thus have a strong financial interest to see CMS reduce its valuation of professional services.

In partnership with ACC, ASE has raised this issue of payor conflict of interest to CMS. While any reimbursement changes to physician work component for echocardiography services would not be implemented before the CY 2021 payment year, ASE and ACC are already at work to defend the current valuation of these codes through available regulatory and legislative channels.

It is important to note that returning to AMA RUC for review and valuation of CPT code 93306 will be challenging.  As shown in the chart below, the majority of codes for which the RUC has recently conducted reviews have resulted in a decrease or even deletion.  ASE will need the support of all members to actively participate in the RUC survey process if called upon.
**Reforming Evaluation and Management (E/M) Payment:** In a significant positive shift stemming from widespread advocacy efforts (including those of ASE), the proposed changes by CMS related to evaluation and management (E/M) services were altered and/or delayed until 2021 in the Final Rule.

CMS finalized changes to streamline E/M documentation for 2019, but the agency has not finalized two proposals opposed by ASE: (1) the application of a multiple-procedure payment reduction to separate E/M services furnished on the same day as a global procedure; and (2) the standardization of the allocation of practice expense RVUs for the E/M services. Both of these proposals would have negatively affected echocardiography payments.

After considering concerns raised by commenters in response to the Proposed Rule, CMS will continue the current coding and payment structure for E/M office and outpatient visits for CY 2019 and CY 2020. Practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare.

Additional modifications to E/M documentation for CY 2019 include the following:

* Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit.
* For established patients, when relevant information is already in the medical record, practitioners can focus documentation on what has changed since the last visit.
* Practitioners do not need to re-enter the defined list of required elements if present, so long as they have reviewed and updated the previous information as needed.
* Practitioners need not re-enter information on the patient's chief complaint and history that has already been entered by ancillary staff or by the patient.
* For E/M visits, CMS has also removed the requirement for teaching physicians to add potentially duplicative documentation in the medical record when that information has been already been provided by residents or other members of the medical team.

Beginning in 2021, CMS will implement a new [payment structure](https://www.cms.gov/sites/drupal/files/2018-11/11-1-2018%2520em%2520payment%2520chart-updated.pdf) for E/M services that collapses Levels 2-4 into a single payment rate. (Recall that in the Proposed Rule, CMS had signaled it intended to collapse all Level 2-5 E/M visits in a single payment rate.)  The new payment structure will apply to both new and established patients. This collapsing of the E/M codes into a single payment rate will impact those specialties (like cardiology) that tend to utilize Level 4 E/M codes. ASE will perform an analysis of the potential impact on the average echocardiography practice.

CMS intends to engage in further discussions with stakeholders over the next few years to potentially refine its policies further. ASE will continue to engage with both the AMA and CMS to ensure the voice of echocardiography is heard so that our members are appropriately reimbursed for the E/M services they provide.

**Practice Expense - Market-Based Supply and Equipment Pricing Update:**  Practice expense (PE) is the portion of the resources used in furnishing a service and reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages. CMS worked with a contractor to conduct a market research study to update the PFS direct PE inputs for supply and equipment pricing for CY 2019. These prices were last systematically evaluated in 2004-2005. A report from the contractor with updated pricing recommendations for approximately 1300 supplies and 750 equipment items currently used as direct PE inputs is available [here](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Downloads/CY2019-PFS-FR-Market-Based-Supply.zip).

CMS is finalizing a proposal to adopt updated direct PE input prices for supplies and equipment. and will do so based on feedback from commenters. ASE has provided direct feedback to CMS, disagreeing with the inputs for large echocardiography equipment.  We will continue to share updated invoices with CMS to address what we believe to be a misguided policy based on larger facility acquisition costs in comparison to average practice acquisition costs.  CMS is also finalizing a proposal to phase-in use of these new prices over a 4-year period beginning in CY 2019.

**Brief Communication Technology-based Service, e.g. Virtual Check-in:**  CMS has finalized its proposal to make separate payment for brief communication technology-based services. The code will be described as G2012 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report E/M services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion). If the service originates from a related E/M service provided within the previous seven days by the same physician or other qualified health care professional, this service would be considered bundled into that previous E/M service and would not be separately billable. In instances when the service leads to an E/M service with the same physician or other qualified health care professional, this service would be considered bundled into the pre- or post-visit time of the associated E/M service, and therefore, would not be separately billable. The bational MPFS payment rate in CY2019 is $14.78 for this new service.

CMS has finalized this proposal allow real-time audio-only telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission.

**Remote Evaluation of Pre-Recorded Patient Information:**  CMS has finalized its proposal to provide separate payment for remote evaluation of pre-recorded patient information. The code will be described as G2010 [Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment]. When the review of the patient-submitted image and/or video results in an in-person E/M office visit with the same physician or qualified health care professional, this remote service will be considered bundled into that office visit and therefore will not be separately billable. In instances when the remote service originates from a related E/M service provided within the previous seven days by the same physician or qualified health care professional, this service will be considered bundled into that previous E/M service and also will not be separately billable. The national MPFS payment rate in CY2019 is $12.61 for this new service.

**Payment Rates for Non-excepted Off-campus Provider-Based Hospital Departments Paid Under the PFS:** In CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.  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 that is 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 has stated that they believe that the PFS Relatively Adjuster encourages fairer competition between hospitals and physician practices by promoting greater payment alignment between outpatient care settings.

**Wholesale Acquisition Cost-Based Payment for Part B Drugs:** Finalizing a Reduction of the Add‑on Amount:  Most Part B drug payments are based on Average Sales Price (ASP) methodology and, by statute, include an add-on payment of 6 percent of the ASP amount. Some Part B drug payments are based on the wholesale acquisition cost (WAC). WAC-based payment amounts typically exceed amounts based on ASP.

CMS has finalized a policy that, effective January 1, 2019, WAC-based payments for Part B drugs determined under section1847A of the Social Security Act, during the first quarter of sales when ASP is unavailable, will be subject to a 3 percent add-on in place of the 6 percent add-on that is currently being used. This change in policy will help curb excessive spending, especially for new drugs with high launch prices, and will also decrease beneficiary cost sharing. The reduction of the add-on percentage for certain WAC-based payments for new Part B drugs is consistent with the Fiscal Year 2019 President's Budget Proposal and MedPAC's June 2017 Report to the Congress.

**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 to allow 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.

**Quality Payment Program's Merit-based Incentive Payment System**

 linician payment adjustments under MIPS are based on scores that clinicians receive in 4 different performance categories, which are weighted as follows:

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| --- | --- | --- | --- |
| **Performance Category** | **CY 2018 Weight\*** | **CY 2019 Weight (Proposed)\*** | **CY 2019 Weight (Final)\*** |
| **Cost (Resource Use)**  | **10%** | **15%** | **15%** |
| **Quality**  | **50%** | **45%** | **45%** |
| **Improvement Activities**  | **15%** | **15%** | **15%** |
| **Promoting Interoperability (formerly Advancing Care Information)** | **25%** | **25%** | **25%** |

\* Weights are reassigned if MIPS eligible clinicians are exempted from a particular performance category.

**Quality Performance Category**: The requirements for the Quality Performance Category of the Merit‑based Incentive Payment System (MIPS) is largely unchanged for the 2019 performance period. The performance period will be the entire 2019 calendar year with the same data completeness requirements as Year 2 of MIPS, depending upon collection type for patients seen during the performance period to which a measure applies remain in place. Performance in the Quality performance category will comprise 45 percent of a MIPS‑eligible clinician's final score for the 2021 MIPS payment year. For the first time in 2019, CMS is allowing MIPS‑eligible clinicians and groups to submit data collected via multiple collection types within a performance category.

**Cost Category:** CMS has finalized its proposal to weigh the cost performance category at 15% of the MIPS score for the 2021 MIPS payment year.  There are no submission requirements for cost measures, as this information is collected from claims data.

For the 2021 payment year, CMS has added eight episode-based cost measures that will let attributed clinicians know the cost of the care provided during the episode's time frame. CMS defines cost based on the allowed amounts on Medicare claims, which include both Medicare payments and beneficiary deductible and coinsurance amounts. Episode-based measures are calculated using Medicare Parts A and B fee-for-service claims data and are based on episode groups.

**Improvement Activities Category:** The performance period for improvement activities will continue as a 90-day continuous period during the calendar year. MIPS‑eligible clinicians must submit a "yes" response for activities within the improvement activities inventory. Improvement activities will constitute 15% of a MIPS‑eligible clinician's total MIPS performance score.

**Promoting Interoperability Category (previously known as the Advancing Care Information):** Beginning with the 2019 performance period, MIPS‑eligible clinicians must use electronic health record (EHR) technology certified to the 2015 Edition certification criteria.

For the 2019 performance period, CMS has finalized a new scoring methodology for the Promoting Interoperability category which is designed to reduce burden for clinicians and enable them to focus more on patient care. MIPS‑eligible clinicians will need to report on all of the required measures across all objectives to earn any score at all for the Promoting Interoperability performance category. Failure to report a required measure or reporting a "no" response on a "yes or no" response measure-unless an exclusion applies-will result in a score of zero.

**Performance Threshold:** CMS has finalized a performance threshold of 30 points for the 2021 payment years. The current threshold is 15 points. MIPS‑eligible clinicians must achieve at least 30 points to avoid a negative payment adjustment. CMS stated that it did not believe it was unreasonable to double the performance threshold and would encourage clinicians to gain experience with all MIPS performance categories. Beginning with the 2024 payment year, CMS will calculate the performance threshold using the mean or median of final performance scores.

**Low-Volume Threshold and MIPS Opt-in Policy:** Beginning with the 2021 MIPS payment year and beyond, clinicians or groups will meet the low-volume threshold if they meet at least one of the following three criteria during the MIPS determination period: (1) those who have allowed charges for covered professional services less than or equal to $90,000; (2) those who provide covered professional services to 200 or fewer Part B- enrolled individuals; or (3) those who provide 200 or fewer covered professional services to Part B-enrolled individuals. Clinicians or groups who do not exceed the low-volume threshold are exempt from participating in MIPS.

For the first time beginning with the 2021 MIPS payment year, if an individual clinician, or group exceeds at least one (but not all) of the low-volume threshold criteria, the individual clinician or group can opt‑in for to participation in MIPS by reporting on applicable measures and activities.

**Small Practice Bonus:** CMS has decided to increase the small practice bonus for the 2021 payment year. A small practice bonus of 6 measure bonus points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices if the MIPS‑eligible clinician submits data to MIPS on at least one quality measure. CMS had proposed a bonus of 3 points. The current bonus is 5 points and is added to the overall performance score.

**Facility-Based Measurement:** CMS will begin to implement facility-based measurement for the 2019 MIPS performance period. A MIPS‑eligible clinician who furnishes >75% of his or her covered professional services in the hospital inpatient, hospital outpatient, or emergency room setting, as identified by place of service codes 21, 22 and 23, is eligible as an individual for facility-based measurement.

CMS is defining a facility-based group as one in which >75%of the clinician's NPI billing under the group's TIN are eligible for facility-based measurement as individuals.

CMS will automatically apply facility-based measurement to eligible individuals and groups; there is no opt-in or opt-out. Individuals and groups who submit quality measures using other submission types would be assigned the higher of the two scores.

There are no submission requirements for individual clinicians in facility-based measurement, but a group must submit data in the Improvement Activities or Promoting Interoperability performance categories to be measured as a group under facility-based measurement.

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Comments are due to CMS no later than 5PM December 31, 2018.