AMERICAN ACADEMY OF FAMILY PHYSICIANS

AAFP summary of the 2019 final Medicare Physician Fee Schedule

On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) released the final rule with comment period titled, "Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019." The AAFP issued a subsequent statement citing that the final rule, "is a step forward in easing administrative burden and improving patient access to care" and that the regulation "follows many of the recommendations provided by" the AAFP. Additionally, *AAFP News* released a related article.

CMS is accepting comments on certain sections by December 31, 2018. CMS released a press release, fact sheet, and E&M Payment Amounts chart. In addition, the agency prepared a fact sheet on the Quality Payment Program (QPP). The AAFP is reviewing the rule and preparing a response to the agency.

2019 Medicare Conversion Factor

CMS bases Medicare physician fee schedule (MPFS) payments on the relative resources typically used to furnish the service. CMS assigns Relative Value Units (RVUs) to each service for physician work, practice expense, and malpractice expense. These RVUs become payment rates through the application of a dollar multiplier known as the "conversion factor." The final 2019 MPFS conversion factor is $36.0391, a slight increase above the 2018 MPFS conversion factor of $35.9996.

Effective Dates

Most of this regulation is effective on January 1, 2019, with some notable exceptions. Sections currently applicable beginning January 1, 2021, include:

- Implementation of a blended payment rate for office/outpatient Evaluation and Management Services (E/M) visits levels 2-4 (levels 1 and 5 are maintained);
- Payment to adjust the base E/M visit rate(s) upward to account for visit complexity associated with non-procedural specialty care and primary care;
- Payment to adjust the base visit rate(s) upward to account for the additional resource costs when physicians or other qualified health care professionals need to spend significantly more time with particular patients; and
- Flexible documentation requirements related to Medical Decision Making, Time, or the Current E/M visit documentation framework.

CMS notes that, *"the 2-year delay in implementation will provide the opportunity for us to respond to the work done by the AMA and the CPT Editorial Panel, as well as other stakeholders. We will consider any changes that are made to CPT coding for E/M services, and recommendations regarding appropriate valuation of new or revised codes."*

Evaluation and Management (E/M) Documentation Guidelines Relief

In the 2019 final rule, per AAFP advocacy and effective on January 1, 2019, CMS has finalized several favorable changes to E/M documentation guideline.

- The requirement to document medical necessity of furnishing visits in the home rather than office will be eliminated.

- Physicians will no longer be required to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated.
- Physicians must only document that they reviewed and verified information regarding chief complaint and history that is already recorded by ancillary staff or the patient.
- CMS removed 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.

Add-on codes
In conjunction with its proposal to implement a single payment rate for level 2 through level 5 office office/outpatient visits, CMS had proposed an add-on code to each office visit performed for primary care purposes and an add-on code for specialties with inherently complex E/M visits. The AAFP called on CMS to eliminate the proposed primary care add-on code and replace it with a 15 percent increase in payment for E/M services, provided by physicians who list their primary practice designation as family medicine, internal medicine, pediatrics, or geriatrics. In the final rule, CMS discussed opposition to the original proposal and did not finalize either add-on code proposal for 2019.

Multiple Procedure Payment Reduction
CMS proposed a Multiple Procedure Payment Reduction (MPPR) policy that would potentially reduce payment by 50 percent for office visits that occur on the same date as procedures or other services. The AAFP opposed application of this policy to primary care practices whose designation is family medicine, internal medicine, pediatrics, or geriatrics. The AAFP expressed opposition to such a policy or any other policy that seeks the reduction of payment for services provided to patients in connection to E/M services. We believe that the valuation of such services, as established through the Relative Value Scale Update Committee process, already accurately accounts for any efficiencies that may exist, and further reductions are not justified. Per AAFP advocacy, CMS did not finalize the proposed MPPR policy.

Site-neutral payment policies
The AAFP supported the CMS proposal to further align payment policies for physicians in independent practice with those whose practices are owned by hospitals. CMS finalized their proposal to maintain the MPFS Relativity Adjuster at 40 percent for 2019, meaning non-excepted items and services are paid at 40 percent of the amount that would have been paid for those services under the outpatient prospective payment system.

Communication Technology-Based Services
The AAFP supported, and CMS its proposal to pay separately for two newly defined physician services furnished using communication technology:
- Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012, approximately $14.78) and
- Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010, approximately $12.61).

CMS also finalized policies to pay separately for new coding describing chronic care remote physiologic monitoring (CPT codes 99453 ($19.46), 99454 ($64.15), and 99457 ($51.54)) and interprofessional internet consultation (CPT codes 99451 ($37.48), 99452 ($37.48), 99446 ($18.38), 99447 ($36.40), 99448 ($54.78), and 99449 ($72.80)).

CMS is also removing the originating site geographic requirements and adding 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.

For 2019, CMS will add HCPCS codes G0513 and G0514 (Prolonged preventive service(s) (both approximately $65.95)) to its list of telehealth services.

Finally, for 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.

Quality Payment Program (Year 3)
Updates for the 2019 QPP performance year and provisions for small practices include:

- Expanding the definition of low-volume threshold to include those who have allowed charges for covered professional services ≤ $90,000; those who provide covered professional services to 200 or fewer Part B-enrolled individuals; or those who provide 200 or fewer covered professional services to Part B-enrolled individuals.
- As supported by the AAFP, giving eligible clinicians who meet or exceed one or two elements of the low-volume threshold the choice to participate in MIPS (referred to as the opt-in policy.)
- Decreasing the quality performance category to 45 percent and increasing the cost performance category to 15 percent.
- Increasing the performance threshold to earn a neutral or positive payment adjustment to 30 points and the exceptional performance threshold to 75 points.
- Requiring the use of 2015 Edition CEHRT. The AAFP opposed the mandate to adopt 2015 Edition CEHRT and suggested CMS create scoring incentives to encourage practices to upgrade.
- Maintaining the 8 percent revenue-based nominal risk standard until performance year 2024, which the AAFP supported.
- Increasing the small practice bonus to 6 points, but including it in the Quality performance category score of clinicians in small practices instead of as a standalone bonus.
- Continuing to award small practices 3 points for submitted quality measures that don’t meet the data completeness requirements.
- Allowing small practices to submit quality data for covered professional services through the Medicare Part B claims submission type for the Quality performance category.
- Providing an application-based reweighting option for the Promoting Interoperability performance category for clinicians in small practices.
- Continuing to provide small practices the option to participate in MIPS as a virtual group.
- Offering no-cost, customized support to small and rural practices through the Small, Underserved, and Rural Support (SURS) technical assistance initiative.

TABLE 94: CY 2019 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$239	0%	-1%	0%	-1%
Anesthesiology	$1,982	0%	0%	0%	0%
Audiologist	$68	0%	1%	0%	1%
Cardiac Surgery	$293	0%	0%	0%	0%
Cardiology	$6,616	0%	0%	0%	0%
Chiropractor	$754	0%	-1%	0%	-1%
Clinical Psychologist	$776	0%	3%	0%	3%
Clinical Social Worker	$728	0%	3%	0%	2%
Colon And Rectal Surgery	$166	0%	1%	0%	1%
Critical Care	$342	0%	-1%	0%	-1%
Dermatology	$3,489	0%	1%	0%	1%
Diagnostic Testing Facility	$734	0%	-5%	0%	-5%
Emergency Medicine	$3,121	0%	0%	0%	0%
Endocrinology	$482	0%	0%	0%	0%
Family Practice	$6,207	0%	0%	0%	0%
Gastroenterology	$1,754	0%	0%	0%	0%
General Practice	$428	0%	0%	0%	0%
General Surgery	$2,090	0%	0%	0%	0%
Geriatrics	$197	0%	0%	0%	0%
Hand Surgery	$214	0%	0%	0%	0%
Hematology/Oncology	$1,741	0%	-1%	0%	-1%
Independent Laboratory	$646	0%	-2%	0%	-2%
Infectious Disease	$649	0%	0%	0%	-1%
Internal Medicine	$10,766	0%	0%	0%	0%
Interventional Pain Mgmt	$868	0%	1%	0%	1%
Interventional Radiology	$384	1%	1%	0%	2%
Multispecialty Clinic/Other Phys	$149	0%	0%	0%	0%
Nephrology	$2,188	0%	0%	0%	0%
Neurology	$1,529	0%	0%	0%	0%
Neurosurgery	$802	0%	0%	0%	0%
Nuclear Medicine	$50	0%	-1%	0%	-1%
Nurse Anes / Anes Asst	$1,242	0%	0%	0%	0%
Nurse Practitioner	$4,060	0%	0%	0%	0%
Obstetrics/Gynecology	$637	0%	0%	0%	0%
Ophthalmology	$5,451	0%	-1%	0%	-1%
Optometry	$1,309	0%	-1%	0%	-1%
Oral/Maxillofacial Surgery	$67	0%	0%	0%	0%
Orthopedic Surgery	$3,741	0%	0%	0%	0%
Other	$31	0%	4%	0%	4%
Otolarngology	$1,222	0%	0%	0%	0%
Pathology	$1,165	0%	-1%	0%	-2%
Pediatrics	$61	0%	0%	0%	0%
Physical Medicine	$1,107	0%	0%	0%	0%
Physical/Occupational Therapy	$3,950	0%	-1%	0%	-1%
Physician Assistant	$2,438	0%	0%	0%	0%
Plastic Surgery	$376	0%	0%	0%	0%
Podiatry	$1,974	0%	2%	0%	2%
Portable X-Ray Supplier	$99	0%	1%	0%	1%
Psychiatry	$1,187	0%	1%	0%	1%
Pulmonary Disease	$1,714	0%	0%	0%	0%
Radiation Oncology And Radiation Therapy Centers	$1,765	0%	0%	0%	-1%
Radiology	$4,907	0%	0%	0%	0%
Rheumatology	$541	0%	0%	0%	0%
Thoracic Surgery	$357	0%	0%	0%	0%
Urology	$1,738	0%	1%	0%	1%
Vascular Surgery	$1,141	0%	2%	0%	2%
Total	$92,733	0%	0%	0%	0%

* Column F may not equal the sum of columns C, D, and E due to rounding.