

Initial Summary of the 2019 Proposed Medicare Physician Fee Schedule

On July 12, 2018, the Centers for Medicare & Medicaid Services (CMS) put on display the [2019 Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Medicare Part B](#). In conjunction with this proposed rule, CMS posted a [press release](#), a [fact sheet](#) and [slides](#) on the proposed rule and a [fact sheet](#) specific to Year 3 of the Quality Payment Program (QPP). The AAFP is reviewing the proposal and will submit comments to CMS before the September 10, 2018 deadline.

2019 Conversion Factor

- CMS estimates that the 2019 physician fee schedule conversion factor will be \$36.0463, a slight increase from the 2018 conversion factor of \$35.9996.

Proposed Evaluation and Management (E/M) documentation and payment

- CMS proposes to collapse payment for office and outpatient visits. Under the proposal, payment for new patient office visits levels 2 through 5 (99202-99205) would be blended into a single \$135 payment. Payment for established patient office visits level 2 through 5 (99212-99215) would be blended into a single \$93 payment.
 - New codes would be created to provide add-on payments to office visits for specific specialties (\$9) and primary care physicians (\$5).
 - Documentation for history and exam will focus on interval history since last visit. Physicians will be allowed to review and verify certain information in the medical record entered by ancillary staff or the beneficiary, rather than re-entering the information. To replace existing documentation guidelines, CMS proposes to allow use of: 1995 or 1997 documentation guidelines, Medical decision-making, or Time.
- When physicians report an E/M service and a procedure on the same date, CMS proposes to implement a 50% multiple procedure payment reduction to the lower paid of the two services.
- CMS will implement new CPT codes and payment for remote monitoring and inter-professional consultations.
 - Medicare would pay physicians for their time when they reach out to beneficiaries via telephone or other telecommunications devices to decide whether an office visit or other service is needed. CMS also proposes to pay for the time it takes physicians to review a video or image sent by a patient seeking care or diagnosis for an ailment.

2019 Quality Payment Program

Regarding proposed changes to the Merit-based Incentive Payment System (MIPS), CMS proposes to:

- Establish the 2019 performance year weights as:
 - Quality: 45%
 - Cost: 15%
 - Promoting Interoperability: 25%
 - Improvement Activities: 15%
- Retain the low-volume threshold, but:

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- Add a third criterion of providing fewer than 200 covered professional services to Part B patients;
- Allow eligible clinicians to opt-in if they meet one or two, but not all, of the low volume threshold criterion; and
- Consolidate the low-volume threshold determination periods for identifying a small practice.
- Retain bonus points for:
 - Care of complex patients,
 - End-to-end reporting, and
 - Small practices (but add this bonus to the quality category score instead of the MIPS final score).
- Eliminate the base and performance categories and reduce the number of measures in the promoting interoperability category (formerly called advancing care information).
- Require eligible clinicians to move to 2015 edition certified electronic health record technology
- CMS plans to allow certain Medicare Advantage plans to qualify as an alternative payment model through a demonstration program called the Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI), which would waive MIPS reporting requirements for clinicians who work within Medicare Advantage networks resembling advanced alternative payment models.

Other provisions in the proposed rule include:

- Updating Practice Expense Relative Value Units (RVUs), Malpractice RVUs, and geographic practice cost indices.
- Identifying potentially misvalued services.
- Establishing payment for care management services and communication technology-based services in Rural Health Clinics and Federally Qualified Health Centers.
- Cutting physician payment for administering new biologics as a drug-price-cutting measure.
- Further developing the policy known as “Appropriate Use Criteria for Advanced Diagnostic Imaging.”
- Seeking comments on how to combat opioid use disorder in Medicare.

TABLE 92: 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