ENDOCRINE SOCIETY
Hormone Science to Health

CY 2019 Physician Fee Schedule
Proposed Rule Summary

On July 11, 2018, the Center for Medicare and Medicaid Services (CMS) released the proposed Medicare Physician Fee Schedule (MPFS) for 2019, which for the first time included proposals on the Quality Payment Program (QPP). The proposed rule updates payment policies and payment rates for Part B services furnished under the MPFS.

The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found here. Comments on the proposal must be submitted by September 10, 2018. The final MPFS is typically published in early November with most of the provisions being effective January 1, 2019 unless stated otherwise.

The following summarizes the major provisions of the proposed rule. Highlighted in bold are specific topics and questions where CMS is seeking comments.

Conversion Factor and Specialty Impact

The conversion factor for 2019 is $36.0463, a slight increase over 2018. The Medicare Access and CHIP Reauthorization Act (MACRA) had authorized a 0.50 percent update for CY 2018, but this was cut in half by the Balanced Budget Act of 2018. The table below, extracted from the rule, shows how the proposed conversion factor was calculated.

Conversion Factor in effect in CY 2018		35.9996
Statutory Update Factor	0.25 percent	
CY 2019 RVU Budget Neutrality Adjustment	-0.12 percent	
CY 2019 Conversion Factor		**36.0463**

Table 94 (see Attachment 1), extracted from the rule, provides a summary of the impact of the proposed changes in the rule by specialty. The changes in the rule are budget-neutral in the aggregate which explains why the impact for all physicians is shown as zero. The 2019 proposed rule is showing changes in the range of minus 5% to plus 4%, with a negative 1% decrease for endocrinology.

Evaluation & Management Visits

In this rule, CMS proposed significant changes to how E/M services will be paid and documented. The proposed changes to the documentation guidelines are intended to reduce administration burden. However, the agency believes these documentation changes are "intrinsically" linked to the payment changes being proposed. The agency is proposing to create a single payment rate for level 2 through 5 new and established patient office visit services. Providers would only be required to document a level 2 office visit regardless of the level of E/M service provided. The agency believes this will reduce audit concerns for physicians. These proposals, as well as other payment changes, are detailed below.

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E/M Documentation Guidelines

In the CY 2018 proposed rule, CMS solicited comments on how to reduce the administrative burden associated with the 1995 and 1997 documentation guidelines for E/M office visits. Stakeholders have maintained that the guidelines are too complex, ambiguous, fail to meaningfully distinguish differences among code levels and are not updated for changes in technology, especially EHR use. CMS solicited additional feedback from stakeholders through the year and received substantially different recommendations by specialty. They also concluded that the history and physical exam portions of the guidelines are significantly outdated with respect to current clinical practice.

CY 2019 Proposed Policies

1) *Eliminating Extra Documentation Requirements for Home Visits*

Medicare pays for home E/M visits (CPT codes 99341 through 99350) at a slightly higher rate than for office visits. Physicians must document the medical necessity of the home visit in lieu of an office or outpatient visit. CMS is proposing to remove this documentation requirement.

2) *Public Comment Solicitation on Eliminating Prohibition on Billing Same-Day Visits by Practitioners of the Same Group and Specialty*

Currently, Medicare will not pay for two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems. CMS now believes there are certain instances where this no longer makes sense and the policy inconveniences patients unnecessarily. ***The agency has requested comment on whether this requirement should be eliminated given the changes in the practice of medicine or whether there is concern that there may be unintended consequences stemming from its elimination.***

3) *Documentation Changes for Office or Other Outpatient E/M Visits and Home Visits*

CMS is proposing to allow physicians to document medical necessity and *choose to document one of the following: medical decision making (MDM), time, or the current 1995 and 1997 guidelines to document the appropriate level E/M visit*. However, all providers will be subject to the proposed E/M payment changes regardless of how they choose to document visits. CMS has linked the documentation and payment proposals.

CMS proposes to create a single payment rate for levels 2 through 5 E/M office and outpatient visits, and only a level 2 visit must be documented to be eligible for this payment. If the provider were to choose to document based on MDM alone, Medicare would only require documentation supporting straightforward medical decision-making measured by two of these three: minimal problems, data review, and risk. ***CMS is proposing to allow practitioners to use MDM in its current form for documentation.***

CMS is proposing to allow providers to use time as a documentation standard for E/M visits, it would no longer just apply to E/M visits in which counseling and/or care coordination accounts for more than half of the face-to-face encounter. The proposal would require the documentation of the time the billing

practitioner spends face-to-face with the patient, as well as the medical necessity of the visit. The agency has outlined three ways to document time for the new E/M payment:

1. CMS has proposed that the typical time for the new E/M payment level is 31 and 38 minutes for established and new patients respectively. These times are the weighted averages of the intra-service times across the current E/M visit utilization.
2. Apply the CPT codebook rule that to bill the service the unit of time is attained when the mid-point is passed (15.5 mins and 19 mins, respectively for established and new patients); or
3. Require documentation that the typical time for the CPT code that is reported was spent face-to-face by the billing practitioner with the patient. The total amount of time spent by the provider face-to-face with a patient would inform the level of E/M visit coded.

Removing Redundancy in E/M Visit Documentation

Stakeholders have recommended that CMS should not require documentation of information in the provider's note that is already present in the medical record, particularly for history and exam. If a provider chooses to continue to document based on the 1995 and 1997 guidelines, the agency proposes several changes. ***CMS proposes to further simplify these requirements by requiring documentation only focus on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a defined list of required elements such as review of a specified number of systems and family/social history. The agency asks if there may be ways to implement similar provisions for any aspects of MDM or for new patients if prior data is available through the EHR or data exchange. For new and established patients, CMS proposes that providers will no longer be required to re-enter information in the record regarding the chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner would only be required to indicate he reviewed and verified the information.***

CMS has specifically solicited comments on the following issues related to the proposed documentation changes:

- **Whether and how guidelines for MDM might be changed in subsequent years if MDM alone is to be used for documenting office visits. Are there ways to further simplify the documentation of MDM?**
- **The use of time as a framework for documentation and whether any of three approaches outlined in the proposed rule or other requirements should be specified.**
- **The total time requirement for payment of the single, new rate for E/M visit levels 2 through 5.**
- **Whether Medicare should use or adopt any aspects of other E/M documentation systems.**

4) Minimizing Documentation Requirements by Simplifying Payment Amounts

In conjunction with CMS' proposal to simplify the E/M documentation requirements, they are proposing to simplify the office-based and outpatient E/M payment rates and create new add-on codes to better capture the differential resources involved in furnishing certain types of E/M visits. CMS believes these proposals will mitigate the burden associated with continuing to use the outdated CPT code set. The agency proposes to pay a single rate for the level 2 through 5 E/M visits for new and established patients. CMS will maintain the current code set even though they recognize that the distinctions

between Medicare visits are not well reflected by the E/M visit coding and does capture distinctions in services and resources.

CMS proposes the following values for the single new and established E/M payment rates, which are based on the average of the current inputs for the codes weighted by 5 years of utilization data:

	New Patient Visits (99202-99205)	**Established Patient Visits (99212-99215)**
RVUs	1.90	1.22
Physician Time (minutes)	37.79	31.31
Direct PE Inputs	$24.98	$20.70

Preliminary Comparison of Payment Rates

HCPCS Code	**CY2018 Non-facility Payment Rate**	**CY2018 Non-facility Payment Rate under the Proposal**
New Patient Office Visits		
99201	$45	$44
99202	$76	$135
99203	$110	
99204	$167	
99205	$211	
Established Patient Office Visits		
99211	$22	$24
99212	$45	$93
99213	$74	
99214	$109	
99215	$148	

The agency proposes to make additional adjustments to single E/M payment rate to better account for the costs of providing E/M services: (1) an E/M multiple procedure payment reduction (MPPR) to account for duplicative resource costs when E/M visits and procedures on the MPPR list are billed together; (2) HCPCS G-code add-ons to recognize additional relative resources for primary care visits and inherent visit complexity that require additional work beyond that which is accounted for in the single payment rates for new and established patient level 2 through 5 visits; (3) HCPCS G-codes to describe podiatric E/M visits; (4) an additional prolonged face-to-face services add-on G code; and (5) a technical modification to the PE methodology to stabilize the allocation of indirect PE for visit services.

- ***Multiple Procedure Payment Reduction***

CMS is proposing to reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit, currently identified on the claim using modifier -25.

- ***Proposed HCPCS G-code Add-ons to Recognize Additional Relative Resources for Certain Kinds of Visits***

These add-on codes only address the additional resources required to furnish the face-to-face portion of office visits performed by a primary care physician or specialist who primarily reports level 4 and 5 visit codes rather than procedural or testing codes. These add-on codes can be billed with every new and established patient office visit.

Primary care add-on: GPC1X (Visit complexity inherent to evaluation and management associated primary medical care services that serve as the continuing focal point for all needed health care services). This code could also be reported for other forms of face-to-face care management, counseling, or treatment of acute or chronic conditions not accounted for by other coding. CMS is not proposing any specialty limitations on billing this code.

Proposed Values for GPC1X	
Work RVUs	0.07
PE RVUs	0.07
Malpractice RVUs	0.01
TOTAL RVUs	**0.15**
Physician Time	1.75 minutes

Specialty add-on: 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**). The agency believes the listed specialties apply predominantly non-procedural approaches to complex conditions that are intrinsically diffuse to multi-organ or neurologic disease.

To value GCG0X, CMS proposes a crosswalk to 75 percent of the work and time of CPT code 90785 (Interactive complexity), an add-on code that may be billed when a psychotherapy or psychiatric service requires more resources due to the complexity of the patient. It results in following proposed values:

Proposed Values for GCG0X	
Work RVU	0.25
PE RVU	0.07
Malpractice RVU	0.01
TOTAL RVUs	**0.33**
Physician Time	8.25 minutes

- ***Technical PE Modification for the Single Rate New and Established Patient E/M Services***

CMS recognizes the distribution of specialties across E/M services would change as a result of this proposal and is concerned about the impact on indirect PE allocations. The agency is proposing to create a single PE/HR value for E/M visits of $136 based on the average of the PE/HR across all specialties that bill E/M codes weighted by the volume of those specialties' allowed E/M services. If this proposal is finalized, CMS will consider revisiting this PE/HR after several years of claims data becomes available.

- ***Proposed HPCPS G-Code for Prolonged Services***

CMS proposes to create a new HCPCS G-code GPRO1 (Prolonged evaluation and management or psychotherapy 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; 30 minutes. This service is half the physician time assigned to CPT code 99354 (Prolonged evaluation and management or psychotherapy 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 hour), so CMS proposes a work RVU of 1.17, half of the value of 99354.

If CMS were to implement the CPT codebook provision that for times services a unit of time is attained when the mid-point is passed, providers could bill this after they spend an additional 16 minutes with the patient.

Impact of proposed changes to E/M policies

CMS modeled the potential impacts of these E/M-related changes (single level 2 through 5 payment rate, application of the MPPR, the primary care and specialty add-on codes, and the PE adjustments) at the specialty-level, but cautions these estimates are imprecise because the model did not account for the full range of technical changes in input data.

Specialty	**Allowed Charges (in millions)**	**Estimated Potential Impact of Valuing Levels 2-5 Together, With Additional Adjustments**
Endocrinology	$482	Minimal change to overall payment

Reimbursement for a Level 4 Established Patient Office Visit	
CY 2018	Policies Proposed in the Rule
$109	$165 *The new payment rate for level 2 through 5 established patient office visit, GPRO1 and GPC1X
	$177 *The new payment rate for level 2 through 5 established patient office visit, GPRO1, and GCG0X

The agency specifically requested comment on the following issues:

- **When the primary care add-on payment is billed, CMS requests information on how to best identify whether or not a primary care visit was furnished particularly in cases when a specialist delivers that care.**
- **Does this policy addresses the deficiencies in CPT coding for E/M services in describing current medical practice and concerns about the impact on payment for primary care and other services?**

- ***Should CMS allow providers to bill the new prolonged E/M code based on the CPT codebook rule that a unit of time is attained when the mid-point is passed? For this service, it would be after providers spend an additional 16 minutes with the patient.***

- **Any other concerns related to primary care the agency should consider in future rulemaking.**
- **If finalized, should CMS delay implementation until January 1, 2020?**

Teaching Physician Documentation Requirements for Evaluation and Management Services

CMS has received feedback that the documentation requirements for E/M services provided by teaching physicians are burdensome and duplicative of notes previously made by residents or other members of the team. The agency is proposing to require that the medical record must document that the teaching physician was present at the time the service is delivered and it can be documented in the note made by the physician, resident, or nurse.

CMS is also proposing to eliminate the requirement for the teaching physician to document the extent of his own participation in the review and direction of the services furnished to each beneficiary and instead allow the resident or nurse to document the extent of the teaching physician's participation as well.

Valuation of Specific Codes

CMS announced proposed work relative values for nearly 200 CPT codes reviewed by the RUC. The agency proposed to accept 71 percent of the RUC recommendations and 81 percent of the RUC's Health Care Professional Advisory Committee recommendations for CPT 2019.

Fine Needle Aspiration (CPT codes 10021, 10X11, 10X12, 10X13, 10X14, 10X15, 10X16, 10X17, 10X18, 10X19, 76492, 77002, 77021)
In June 2017, CPT deleted code 10022, revised, CPT code 10021, and created nine new codes to describe fine needle aspiration procedures with and without imaging guidance. CMS is proposed the RUC-recommended work values for 7 of the 10 codes in the family. The agency did not propose all of the recommended work RVUs because they did not believe they would maintain relativity. They note that the work pool for the revised family is increasing by approximately 20 percent for the family and the work time pool is only increasing by about 2 percent. CMS does not believe the code revisions resulted in an increase in the service intensity to justify that would be needed to justify all the RUC-recommended work values.

Code	Descriptor	Recommended RVUs
10021	Fine needle aspiration biopsy, without imaging guidance; first lesion	1.03 *Based on a direct crosswalk to CPT code 36440*
10X11	Fine needle aspiration biopsy, without imaging guidance; each additional lesion	0.80 *RUC recommendation*

10X12	Fine needle aspiration biopsy, including ultrasound guidance; first lesion	1.46 *CMS agrees the relative difference in work between 10021 and 10X12 is 0.43 RVUs, and this recommendation is based upon the agency's recommendation for 10021.*
10X13	Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion	1.00 *RUC recommendation*
10X14	Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion	1.81 *RUC recommendation*
10X15	Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion	1.18 *RUC recommendation*
10X16	Fine needle aspiration biopsy, including CT guidance; first lesion	2.26 *CMS does not agree with the RUC recommendation, but does agree with the relative difference of 1.23 RVUs between 10021 and 10X16.*
10X17	Fine needle aspiration biopsy, including CT guidance; each additional lesion	1.65 *RUC recommendation*
10X18	Fine needle aspiration biopsy, including MR guidance; first lesion	*Recommending contractor pricing until utilization increases*
10X19	Fine needle aspiration biopsy, including MR guidance; each additional lesion	*Recommending contractor pricing until utilization increases*
77021	Magnetic resonance guidance for needle placement, radiological supervision and interpretation	1.50 *RUC recommendation*
76942	Ultrasonic guidance for needle placement, imaging supervision and interpretation	0.67 *Reaffirms current RVUs*
77002	Fluoroscopic guidance for needle placement	0.54 *Reaffirms current RVUs*

Chronic Care Remote Physiologic Monitoring (CPT codes 990X0, 990X1, 994X9)
CPT created these codes to describe remote physiologic monitoring and management. 990X0 and 990X1 are both PE only codes. CMS is proposed the RUC-recommended value for 994X9.

Code	**Descriptor**	**Recommended RVUs**
990X0	Remote monitoring of physiologic parameter(s), initial; set-up and patient	PE only

	education on use of equipment	
990X1	Remote monitoring of physiologic parameter(s), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days	PE only
994X9	Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication with the patient/caregiver during the month	0.61

Diabetes Management Training (HCPCS codes G0108 and G0109)
These codes were identified as part of a screen of codes with Medicare utilization greater than 100,000 services annually. CMS is proposing the HCPCS-recommended work RVUs for these services. The agency was concerned about the series of different syringes and the patient education booklet that were removed from the PE inputs and is instead proposing to maintain the current direct PE inputs, rather than the reduced inputs recommended by HCPCS.

Code	**Descriptor**	**Recommended RVUs**
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	0.90
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes	0.25

Interprofessional Internet Consultation (CPT code 994X0, 994X6, 99446, 99447, 99448, 99449)
CPT revised 4 existing codes and created 2 new codes to describe interprofessional telephone/internet/electronic medical record consultation services. CPT codes 99446-99449 had previously considered to be bundled services and were not separately payable. CMS is proposing to convert these to active codes based on changes in medical practice and technology. CMS affirmed the work RVUs for the existing codes and proposed the RUC-recommended value for 994X0 and made a different recommendation for 994X6. ***The agency requests comment on this proposal.***

Code	Descriptor	Recommended RVUs
994X0	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating /requesting physician or qualified healthcare professional, 30 minutes	0.50 *RUC recommendation*
994X6	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting/ physician or other qualified healthcare professional	0.50 *CMS believes this should be valued the same as 994X0 because they have similar intraservice times.*
99446	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 5-10 minutes of medical consultative discussion and review	0.35
99447	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 11-20 minutes of medical consultative discussion and review	0.70
99448	Interprofessional telephone/Internet assessment and management service provided by a consultative physician	1.05

	including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 21-30 minutes of medical consultative discussion and review	
99449	Interprofessional telephone/Internet assessment and management service provided by a consultative physician including a verbal and written report to the patient's treating/requesting physician or other qualified health care professional; 31 minutes or more of medical consultative discussion and review	1.40

Remote pre-recorded services (HCPCS code GRAS1)
CMS is proposing to pay separately for remote services when a physician uses pre-recorded video and/or images submitted by the patient for evaluation of the patient's condition.

GRAS1 (Remote evaluation of recorded video and/or images submitted by the patient (e.g. store and forward), including interpretation with verbal 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)

The agency is proposing a direct crosswalk to CPT code 93793 (Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ration test result, patient instructions, dosage adjustments (as needed), and scheduling of additional test(s), when performed) because the agency believes the work is similar in time and intensity. CMS is proposing a work RVU of 0.18, preservice time of 3 minutes, intraservice time of 4 minutes, and post service time of 2 minutes, as well as 6 minutes of clinical labor. ***CMS request comment on the proposed code descriptor and value.***

Code	**Descriptor**	**Recommended RVUs**
GRAS1	Remote evaluation of recorded video and/or images submitted by the patient (e.g. store and forward), including interpretation with verbal follow-up with the patient within 24 business hours, not originating from a related E/M	0.18

	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	

Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCI1)
CMS is proposing to create a new G-code to pay for brief communication technology-based services.

GVCI1 (Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health professional who may report evaluation and management 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)

The descriptor and valuation were based on CPT code 99441 for telephone evaluation and management services. CMS is proposing a work RVU of 0.25 based on a direct crosswalk to 99441.

CMS requests comments on the code descriptor and valuation, as well as whether separate coding and payment is needed for different communication modalities.

Code	Descriptor	Recommended RVUs
GVCI1	Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health professional who may report evaluation and management 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	0.25

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

The Social Security Act limits the Secretary's ability to expand telehealth services. However, the recently passed Bipartisan Budget Act of 2018 (BBA) modified the requirements, particularly those for originating sites for certain services, including home dialysis end-stage renal disease (ESRD)-related services,

services from practitioners who participate in Accountable Care Organizations (ACOs), and acute stroke-related services. Besides implementing the provisions of the BBA, CMS is proposing to pay separately for other telehealth services.

Also, CMS proposes to expand access to medical care using telecommunications technology by proposing to cover a number of new services and is proposing new codes to bill for these services under the PFS: Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCI1) and Remote Professional Evaluation of Recorded Video and/or Images Technology Submitted by the Patient, e.g. Store and Forward Services (HCPCS code GRAS1).

CMS requests public comment on the following issues related to the new Virtual Check-in code:

- ***The types of communication technology used by physicians or other health care professionals for brief non-face-to-face check-ins with patients to assess whether the patient should have an office visit, including whether audio-only telephone interactions are sufficient compared to video interactions or other kinds of data transmission***
- ***Whether the rule should require consent to receiving these services, for example verbal consent that would be noted in the medical record for each service.***
- ***Whether it would be clinically appropriate to apply a frequency limitation on the use of this code by the same practitioner within the same patient, and on what would be a reasonable frequency limitation***
- ***What timeframes under which this service would be separately billable compared to when it would be bundled and whether they should consider broadening the window of time and/or circumstances in which this service should be bundled into the subsequent related visit.***
- ***How clinicians could best document the medical necessity of this service, consistent with documentation requirements necessary to demonstrate the medical necessity of any service under PFS.***
- ***The proposed definition and valuation of the service.***

CMS seeks public comment on the new service to evaluate patient provided videos and images:

- ***Whether these services should be limited to established patients or where and/or when it might be appropriate for a new patient to receive these remote services.***
- ***The proposed definition and valuation of the service.***

CMS is also proposing to pay separately for Chronic Care Remote Physiologic Monitoring (CPT codes 990X0, 990X1, and 994X9) and Interprofessional Internet Consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449). The agency believes these codes will result in improved payment accuracy for primary care and care management services.

Regarding the Interprofessional Internet Consultation codes, CMS seeks public comment on:

- ***Are these separately identifiable services and can they be distinguished from similar services?***
- ***How to best minimize potential program integrity issues and whether these types of services are paid separately by private payers and if so, what controls or limitations private payers have put in place to ensure these services are billed appropriately.***

Potentially Misvalued Services

Update on the Global Surgery Data Collection

MACRA required CMS to implement a process to collect data on the number and level of postoperative visits and to use this data to assess the valuation of surgical globals. The agency developed a process to collect data from groups with 10 or more practitioners in 9 states on the no-pay CPT code 99204 to report postoperative visits. Of practitioners that met the criteria for reporting, only 45 percent participated, varying substantially by specialty.

A set of "robust reporters" was identified in the data. Among this group, CMS found 87 percent of procedures with 90-day global periods had one or more associated postoperative visits. Only 16 percent of procedures with a 10-day global period had an associated postoperative visit reported. This data suggests that the postoperative visits included in the 10-day global periods are not being performed.

CPT code 99204 is intended to collect information on the number of postoperative visits, but not the level of these visits. CMS anticipates beginning a separate survey-based data collection effort on the visit level, including time, staff, and activities involved in these visits, as well as non-face-to-face services.

CMS is requesting comment on the following issues:

- ***How to encourage reporting of CPT code 99204 to ensure the validity of the data;***
- ***Whether they need to do more to make practitioners aware of this reporting obligation and if an enforcement mechanism should be implemented;***
- ***Whether it might or might not be reasonable to assume many visits included in the 10-day global packages are not being performed or if there are alternative explanations;***
- ***Whether it is possible that some or all of the postoperative visits are occurring after the global period ends and are reported and paid separately;***
- ***Should CMS require the use of modifier 54 "for surgical care only" and modifier 55 "postoperative management only" in cases where the surgeon does not expect to perform the postoperative visit regardless of whether there is formal transfer of care;***
- ***Should CMS consider changing the 10-day global period and reviewing the code valuation.***

Changes to Direct PE Inputs for Specific Services

Market-Based Supply and Equipment Pricing Update

The Protecting Access to Medicare Act of 2014 (PAMA) provided that the Secretary may collect or obtain information from any eligible professional on the resources directly or indirectly related to the delivery of fee schedule services. Under this authority, CMS initiated hired a contractor to conduct a market research study to update the direct PE inputs for supply and equipment pricing for CY 2019. These prices were last updated in 2004-2005. A report with updated pricing for approximately 1300 supplies and 750 equipment items has been submitted and is available in the downloads section that accompanies the proposed rule. Based on this report, CMS is proposing to adopt the updated direct PE input prices for supplies and equipment over a 4-year period beginning in CY 2019 because of the potentially significant changes in payment that would occur. The pricing for many equipment and

supply items is increasing as a result. The agency is proposing to use a 25/75 percent split between new and old pricing in year one, 50/50 in year two, 75/25 in year three, and 100/0 in year four. Along with the full report, a spreadsheet showing the phased in values is available for download. The CY 2019 PE values found in Addendum B reflect this 25/75 pricing phase in. New supply and equipment codes that are implemented during this 4-year period will be fully implemented with no transition.

To maintain relativity between the clinical labor, supplies, and equipment portions of the PE methodology, CMS want to update the rates for clinical labor staff and seeks comment on whether to update clinical labor wages used to develop PE RVUs in future calendar years during the transition period or whether it would be more appropriate to do at the conclusion of the transition period.

Payment for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Departments of Hospitals

Starting in January 2017, CMS no longer recognized under the Hospital Outpatient Prospective Payment System (OPPS) certain items and services furnished by certain off-campus provider-based departments (PBDs) and paid for these services under the fee schedule. In 2017, payment for these services were paid at 50% of the OPPS payment rate and in 2018 payment was set at 40% of the OPPS rate. This payment policy is called the PFS Relativity Adjuster. In addition, all claims for these services were submitted with specific modifiers, so that CMS could determine future payment levels that would be more appropriate for PBDs.

For CY 2019, CMS is proposing to continue applying the PFS Relativity Adjuster of 40%, which means that nonexcepted items and services furnished by nonexcepted off-campus PBDs will be reimbursed at 40% of the OPPS payment rate. CMS is also maintaining the same geographic adjustment and beneficiary cost sharing policies that were in effect in CY 2018.

Note: Services that are "excepted" from this payment change are provided in: dedicated emergency departments; off-campus PBDs that were billing for covered outpatient department services furnished prior to November 2, 2015; in "on campus" PBDs or within 250 yards of the hospital or a remote location of the hospital. All services that do not meet these requirements are considered "non-excepted."

Part B Drugs: Application of Add-on Percentage for certain WAC-based payments

Drugs are typically reimbursed under Medicare Part B at the average sales price (ASP) for the drug or biological plus a 6% add-on payment. Part B payments are based on the wholesale acquisition cost (WAC) of the drug or biological when ASP is not available during the first quarter of sales or when Medicare Administrative Contractors determine pricing, which is for drugs not appearing on the ASP pricing files or for new drugs. The WAC of a drug typically exceeds the ASP, as it does not include any prompt pay or other discounts, rebates or reductions in price included in the ASP.

CMS is proposing, effective January 1, 2019, to reduce payment for drugs when WAC-based payments are being used by reducing the add-on percentage to 3% (from 6%). The proposal is based on a 2014 OIG Report and recommendations from MedPAC to achieve greater parity between ASP-based acquisition costs and WAC-based payments for Part B drugs.

Medicaid Promoting Interoperability Program Requirements for EPs

In response to previous stakeholder feedback supporting quality measure alignment between the Medicare Incentive Payment System (MIPS) and the Medicaid Promoting Interoperability Program, CMS is proposing to amend the list of electronic clinical quality measures (eCQMs) for the CY 2019 performance year. Specifically, CMS proposes to align the eCQMs available in 2019 with those available for the MIPS eligible clinicians for CY 2019. CMS believes that aligning the eCQMs available in these programs would ensure a uniform application of up-to-date clinical standards and guidelines, while also reducing burden for Medicaid EPs.

CMS seeks public comment on whether in future years of the Medicaid Promoting Interoperability Program beyond 2019 all e-specified measures from the set of quality measures for Medicaid and the Children's Health Insurance Program (CHIP) (the Child Core Set) and the core set of health care quality measures for adults enrolled in Medicaid (Adult Core Set) as additional options for Medicaid EPs.

Medicare Shared Savings Program

CMS is proposing changes to the Medicare Shared Savings Program (MSSP) to reduce administrative burden, eliminate redundant measures, and focus quality reporting on outcomes and patient experience measures. The agency proposes to eliminate 10 measures from and add 1 measure to the program. This would reduce the number of quality measures in the program from 31 to 24. Several of the changes are included in the patient experience of care survey referred to as the Consumer Assessment of Healthcare Provider and Systems (CAHPS) for ACOs Survey. Table 25 shows the proposed Shared Savings Program quality measure set for performance year 2019 and following years. ***CMS requests comments on the proposed changes to the MSSP measure set.***

Physician Self-Referral Law

The physician self-referral law prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies. The law also prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third-party payer) for those referred services.

The statute establishes specific exceptions and CMS is proposing revisions which mirror provisions recently made in the BBA, while also addressing differences in the statutory and regulatory language. With this, CMS clarifies the requirements for written agreements and signatures. CMS codifies the agency's existing policy that allows a collection of documents to satisfy the requirement for a compensation agreement to be in writing.

CMS also proposes that the signature requirement can be satisfied if the compensation agreement complies with all criteria of the exception and also is obtained "90 consecutive calendar days immediately following the date" of a required signature.

ATTACHMENT 1

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

(A)	(B)	(C)	(D)	(E)	(F)
Specialty	**Allowed Charges (mil)**	**Impact of Work RVU Changes**	**Impact of PE RVU Changes**	**Impact of MP RVU Changes**	**Combined Impact***
TOTAL	$92,173	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	$238	1%	-6%	0%	-5%
ANESTHESIOLOGY	$1,889	0%	0%	0%	0%
AUDIOLOGIST	$67	0%	0%	-1%	-1%
CARDIAC SURGERY	$293	-1%	-1%	1%	-1%
CARDIOLOGY	$6,590	0%	-1%	0%	-1%
CHIROPRACTOR	$749	0%	1%	0%	0%
CLINICAL PSYCHOLOGIST	$770	0%	2%	0%	2%
CLINICAL SOCIAL WORKER	$725	0%	2%	0%	2%
COLON AND RECTAL SURGERY	$165	0%	1%	0%	1%
CRITICAL CARE	$340	-1%	0%	0%	0%
DERMATOLOGY	$3,477	1%	-2%	0%	-1%
DIAGNOSTIC TESTING FACILITY	$728	0%	-4%	0%	-4%
EMERGENCY MEDICINE	$3,110	0%	0%	0%	0%
ENDOCRINOLOGY	$480	0%	-1%	0%	-1%
FAMILY PRACTICE	$6,176	0%	1%	0%	1%
GASTROENTEROLOGY	$1,750	-1%	1%	0%	1%
GENERAL PRACTICE	$423	0%	1%	0%	1%
GENERAL SURGERY	$2,079	0%	0%	0%	1%
GERIATRICS	$196	-2%	1%	0%	-1%
HAND SURGERY	$213	2%	1%	0%	2%
HEMATOLOGY/ONCOLOGY	$1,737	-1%	-3%	0%	-4%
INDEPENDENT LABORATORY	$640	0%	4%	0%	4%
INFECTIOUS DISEASE	$645	-1%	1%	0%	0%
INTERNAL MEDICINE	$10,698	0%	1%	0%	1%
INTERVENTIONAL PAIN MGMT	$863	2%	1%	0%	3%
INTERVENTIONAL RADIOLOGY	$384	1%	-1%	0%	0%
MULTISPECIALTY CLINIC/OTHER PHYS	$148	-1%	0%	0%	-1%
NEPHROLOGY	$2,182	-1%	0%	0%	-1%
NEUROLOGY	$1,521	-1%	-1%	0%	-2%
NEUROSURGERY	$798	0%	0%	1%	1%
NUCLEAR MEDICINE	$50	-1%	-1%	0%	-1%
NURSE ANES / ANES ASST	$1,163	0%	0%	0%	0%
NURSE PRACTITIONER	$4,043	1%	2%	0%	2%
OBSTETRICS/GYNECOLOGY	$635	3%	1%	0%	4%

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(A)	(B)	(C)	(D)	(E)	(F)
Specialty	**Allowed Charges (mil)**	**Impact of Work RVU Changes**	**Impact of PE RVU Changes**	**Impact of MP RVU Changes**	**Combined Impact***
OPHTHALMOLOGY	$5,437	0%	-1%	0%	-1%
OPTOMETRY	$1,301	1%	0%	0%	1%
ORAL/MAXILLOFACIAL SURGERY	$67	1%	-2%	0%	-1%
ORTHOPEDIC SURGERY	$3,730	1%	0%	0%	1%
OTHER	$31	0%	5%	0%	4%
OTOLARNGOLOGY	$1,206	2%	-3%	0%	-1%
PATHOLOGY	$1,158	0%	-1%	0%	-1%
PEDIATRICS	$61	-1%	0%	0%	-1%
PHYSICAL MEDICINE	$1,102	-1%	0%	0%	-1%
PHYSICAL/OCCUPATIONAL THERAPY	$3,930	0%	-1%	0%	-1%
PHYSICIAN ASSISTANT	$2,447	1%	0%	0%	1%
PLASTIC SURGERY	$373	1%	0%	0%	1%
PODIATRY	$1,958	-1%	0%	0%	-2%
PORTABLE X-RAY SUPPLIER	$98	0%	1%	0%	1%
PSYCHIATRY	$1,177	0%	2%	0%	3%
PULMONARY DISEASE	$1,709	-2%	0%	0%	-2%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	$1,760	0%	-2%	0%	-2%
RADIOLOGY	$4,891	0%	0%	0%	0%
RHEUMATOLOGY	$540	-1%	-3%	0%	-4%
THORACIC SURGERY	$356	-1%	-1%	1%	-1%
UROLOGY	$1,733	2%	1%	0%	3%
VASCULAR SURGERY	$1,144	0%	-2%	0%	-1%
* Column F may not equal the sum of columns C, D, and E due to rounding.					

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