Six Things to Know About the Proposed 2019 Medicare Physician Fee Schedule

The Agency is proposing to implement a variety of changes to regulations, payments, and payment policies to ensure that the Medicare payment systems reflect changes in medical practice and the relative value of services. This proposed rule also includes suggested changes to the Quality Payment Program.

1. **Evaluation and Management CPT Codes**
   A. The Agency is proposing to minimize documentation requirements, while collapsing payment rates for most New and Established patient visits.*
      a. They propose to apply a minimum documentation standard where, for the purposes of PFS payment for an office/outpatient E/M visit, practitioners would only need to meet documentation requirements currently associated with a level 2 visit for history, exam and/or MDM (except when using time to document the service).
      b. Practitioners would only be required to focus their documentation 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.
      b. In conjunction with the proposal to reduce the documentation requirements for E/M visit, CMS is proposing to simplify the payment for those services by paying a single rate for the level 2 through 5 E/M visits.
   B. The Agency is also proposing to create new add-on codes to better capture the differential resources involved in furnishing certain types of E/M visits. *
      a. CMS proposes to create several new codes to capture additional costs beyond the typical resources expended by a subset of specialty providers.
      b. CMS proposes to adjust the resource inputs for current E&M codes

   C. CMS has also proposed to institute a multiple procedure payment adjustment for duplicative resource costs when E&M visits are provided on the same day as a minor procedure. Specifically, they will reduce payment by 50% for the least expensive procedure or visit provided by the same clinician on the same day as an E&M

2. **Global Surgery Data Collection** – CMS indicates data collection of post-operative visits via claim forms has been unsuccessful this far and is questioning if the lack of reporting shows a lack of follow-up or a transfer of care not correctly reported via modifiers. *
   A. CMS is soliciting suggestions as to how to encourage reporting of post-operative visits to ensure the validity of data collection. (In 2017, groups of 10 or more practitioners in 9 states became mandated reports of code 99024 for each post-op visit. Providers in other states could voluntarily submit data.)
   B. CMS also anticipates the release of a new survey-based data collection effort to identify the level of post-op visits, the time necessary for the visit, the staff and activities involved in providing care.

Background information is available at the end of this document on items marked with an *

3. **Quality Payment Program Changes for 2019**
    A. CMS is adding a third criterion for determining MIPS eligibility. To be excluded from MPS, clinicians or groups would need to meet one of the following three criterion: Have less than $90,000 in allowed charges for covered services -OR- have provided care to 200 or less Part B patients -OR- *(a new criterion) provided 200 or less covered professional services under the Medicare fee schedule.*
        i. If a clinician meets or exceeds at least one, but not all, they may choose to opt in.
            1. The Opt-in process is (still) being developed.
        ii. CMS estimates 650,000 clinicians will be eligible to participate in the QPP in 2019, with $372 million available for positive payment adjustments.
        iii. If a clinician is eligible and they choose not to report, there will be a -7% adjustment to 2021 payments.
        iv. There are two determination periods; October 1, 2017- September 30, 2018 and October 1, 2018- September 30, 2019.
    B. Eligible clinicians will be expected to report:
        i. Quality and cost information for 365 calendar days
        ii. Promoting Interoperability and Improvement Activities for any 90 days, up to 365 days.
    C. Performance threshold raised to 30 points. Meeting this threshold will avoid the penalty, and payments will receive a neutral adjustment in 2021.
        i. Additional bonus opportunity threshold raised to 80 points
    D. Breakdown of scoring:
        i. Quality = 45% of final score
            1. Must (still) report 6 measures, including 1 outcome measure
            2. Must also still report 60% of all patients regardless of payor to meet data completeness requirements.
            3. Groups will no longer be able to report their quality data through claims.
        ii. Cost = 15%
            1. 8 new episode based cost measures. Mixture of procedural and acute episodes. (None relevant to Plastics however.)
        iii. Improvement Activities = 15%
            1. Adding 6 new activities for 2019 – 2 may be of value to Plastic Surgeons
                a. Financial Navigation Program (**IA_BE_XX)** *
                b. Relationship Centered Communications (I**A_CC_XX)** *
        iv. Promoting Interoperability = 25%
            1. Must use 2015 edition of CEHRT

4. **Off-campus Provider-based Departments of a Hospital**
    A. For 2019, services must be reported with the -PN modifier
    B. Reimbursement will be at 40% of the OPPS rate

Background information is available at the end of this document on items marked with an *

5. **Appropriate Use Criteria**
    A. CMS provides clarification on who must use a qualified clinical decision support mechanism when ordering or performing advanced diagnostic imaging services.
6. **Setting the 2019 Conversion Factor**
    A. The Agency indicates $36.0463 will be the new conversion factor. This represents a $ 0.434 increase from 2018.
    B. CMS projects plastic surgeons who successfully participate in the QPP will see a 1% increase in Medicare payments.

BACKGROUND INFORMATION

Item 1A – Proposed Payment Rates for E&M Services

CMS is proposing a step-wise approach to the issue, focusing initially on office/outpatient codes 99201-99205 and 99211- 99215.

Comparison of Payment Rates for Office Visits New Patients		
CPT Code	Current Non-Facility Payment Rate	Proposed Non-Facility Payment Rate
99201	$ 45.00	$ 44.00
99202	$ 76.00	$135.00
99203	$ 110.00	
99204	$ 167.00	
99205	$ 211.00	

Comparison of Payment Rates for Office Visits Established Patients		
CPT Code	Current Non-Facility Payment Rate	Proposed Non-Facility Payment Rate
99211	$ 22.00	$ 24.00
99212	$ 45.00	$ 93.00
99213	$ 74.00	
99214	$ 109.00	
99215	$ 148.00	

Item 1B – New Add-On codes for E&M visits.
CMS reports that certain specialists, like neurologists and endocrinologists, for example, bill higher level E/M codes more frequently than procedural specialists. This appears to a result of the treatment approach utilized. Visits furnished for primary care may also involve distinct resource costs. To adequately capture those costs, CMS is proposing the use of "G" codes. Note – two of the three can be reported by some, but not all specialties.

HCPC Code	Description	Valuation
GPC1X	Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an established patient evaluation and management visit).	Work RVU: 0.07, Physician time: 1.75 minutes, PE RVU: 0.07, MP RVU: 0.01 **Proposed reimbursement: $5.00**
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 (Add-on code, list separately in addition to an evaluation and management visit).	Work RVU: 0.25, Physician time: 8.25 minutes PE RVU: 0.07, MP RVU: 0.01 **Proposed reimbursement: $14.00**
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	Work RVU: 1.17 **Proposed reimbursement: $67.41**

1C. Multiple Procedure Payment Adjustments
As part of their proposal to make payment for the E/M levels 2 through 5 at a single PFS rate, CMS would 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, reported on the claim by an appended modifier -25.

Example - New patient visit 99203 with 3.2 cm benign neck lesion removal same day

Billed as	Reimbursed as
11424 $240.12 (estimated 2019 limiting charge)	11424 $ 192.10 (80% of approved amount)
99203-25 $135.00 (proposed 2019 limiting charge)	99203-25 $ 54.00 (80% of approved plus reduction of 50%)
Total billed $ 375.12	Total paid: $ 246.10
	Co-Pay eligible: $ 61.52 Uncollectible: $ 67.50

Item 2 – Global Surgery Data Collection

Plastic Surgeons in groups of 10 or more, who live in Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon or Rhode Island and who bill the following codes may be impacted

CPT Code	Description
11406	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), trunk, arms or legs; excised diameter over 4.0 cm
11423	Excision, benign lesion including margins, except skin tag (unless listed elsewhere), scalp, neck, hands, feet, genitalia; excised diameter 2.1 to 3.0 cm
11442	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 1.1 to 2.0 cm
11443	Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 2.1 to 3.0 cm
11643	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 2.1 to 3.0 cm
11644	Excision, malignant lesion including margins, face, ears, eyelids, nose, lips; excised diameter 3.1 to 4.0 cm
13160	Secondary closure of surgical wound or dehiscence, extensive or complicated
14020	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10 sq cm or less
14021	Adjacent tissue transfer or rearrangement, scalp, arms and/or legs; defect 10.1 sq cm to 30.0 sq cm
14040	Adjacent tissue transfer or rearrangement, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands and/or feet; defect 10 sq cm or less
14060	Adjacent tissue transfer or rearrangement, eyelids, nose, ears and/or lips; defect 10 sq cm or less
14301	Adjacent tissue transfer or rearrangement, any area; defect 30.1 sq cm to 60.0 sq cm
15100	Split-thickness autograft, trunk, arms, legs; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15120	Split-thickness autograft, face, scalp, eyelids, mouth, neck, ears, orbits, genitalia, hands, feet, and/or multiple digits; first 100 sq cm or less, or 1% of body area of infants and children (except 15050)
15240	Full thickness graft, free, including direct closure of donor site, forehead, cheeks, chin, mouth, neck, axillae, genitalia, hands, and/or feet; 20 sq cm or less
15732	Muscle, myocutaneous, or fasciocutaneous flap; head and neck (eg, temporalis, masseter muscle, sternocleidomastoid, levator scapulae)
15734	Muscle, myocutaneous, or fasciocutaneous flap; trunk

Background information is available at the end of this document on items marked with an *

CPT Code	Description
19357	Breast reconstruction, immediate or delayed, with tissue expander, including subsequent expansion

Item 3D. III – Newly Proposed Improvement Activities

Proposed Improvement Activity
Proposed Activity ID: IA_BE_XX
Proposed Subcategory: Beneficiary Engagement
Proposed Activity Title: Financial Navigation Program
Proposed Activity Description:
In order to receive credit for this activity, MIPS eligible clinicians must attest that their practice provides financial counseling to patients or their caregiver about costs of care and an exploration of different payment options. The MIPS eligible clinician may accomplish this by working with other members of their practice (for example, financial counselor or patient navigator) as part of a team-based care approach in which members of the patient care team collaborate to support patient centered goals. For example, a financial counselor could provide patients with resources with further information or support options, or facilitate a conversation with a patient or caregiver that could address concerns. This activity may occur during diagnosis stage, before treatment, during treatment, and/or during survivorship planning, as appropriate.
Proposed Weighting: Medium
Rationale: CMS believes there is the possibility for improved outcomes when financial navigation programs are in place, such as reducing patient anxiety about costs and improved access to care for underserved populations. For these reasons, CMS believes this activity meets the inclusion criteria of an activity that could lead to improvement in practice to reduce health care disparities.

CMS is proposing the weighting of this activity as medium because the activity may be accomplished by providing literature and/or facilitating a conversation with a patient during a regular visit. This task may be incorporated into a patient's regular visit with a relatively low investment of time or resources.

Proposed Improvement Activity
Proposed Activity ID: IA_CC_XX
Proposed Subcategory: Care Coordination
Proposed Activity Title: Relationship-Centered Communication
Proposed Activity Description:
In order to receive credit for this activity, MIPS eligible clinicians must participate in a minimum of eight hours of training on relationship-centered care[80] tenets such as making effective open-ended inquiries; eliciting patient stories and perspectives; listening and responding with empathy; using the ART (ask, respond, tell) communication technique to engage patients, and developing a shared care plan. The training may be conducted in formats such as, but not limited to: interactive simulations practicing the skills above, or didactic instructions on how to implement improvement action plans, monitor progress, and promote stability around improved clinician communication.
Proposed Weighting: Medium
Rationale: There is currently not an activity in the Inventory that addresses communication between patients and clinicians; this proposed activity would help fill a gap. CMS believes that this proposed activity meets the inclusion criteria of an activity that is likely to lead to improved beneficiary health outcomes based on research citing the importance of relationship-centered care to patient safety.

CMS is proposing the weighting of this activity as medium because participation in an eight-hour training on relationship-centered care, though beneficial, does not require substantial time or effort by clinicians.