



Medicare Physician Fee Schedule Proposed Rule for Calendar Year 2019 Detailed Summary of the Payment Provisions

The American College of Radiology (ACR) has prepared this detailed analysis of proposed changes to the payment provisions of the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2019. The ACR will provide detailed comments by the September 10th comment period deadline. If finalized, the rule changes will be effective Jan. 1, 2019.

Conversion Factor

CMS estimates a CY 2019 conversion factor of \$36.0463, which reflects the 0.25 percent update specified by the Medicare Access and CHIP Reauthorization Act and a budget neutrality adjustment of -0.12 percent. Overall, this is a slight increase from the current conversion factor of \$35.9996.

CMS estimates an overall impact of the MPFS proposed changes to radiology and interventional radiology to be a neutral 0 percent change, while nuclear medicine would see an aggregate decrease of 1 percent and radiation oncology and radiation therapy centers a 2 percent decrease if the provisions within the proposed rule are finalized.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services (Page 437*)

Background and Program Overview

The Protecting Access to Medicare Act of 2014 included a provision for the mandatory use of appropriate use criteria (AUC) for advanced diagnostic imaging services. Through the CY 2016 rulemaking process, CMS addressed the initial component of the AUC program, specifying applicable AUC. CMS established a process for the development of AUC, defined provider-led entities (PLEs), and established the process by which PLEs may become qualified to develop AUC. The first list of [qualified PLEs](#) was posted on the CMS website in late June 2016.

The CY 2017 Medicare Physician Fee Schedule (MPFS) final rule identified the requirements clinical decision support mechanisms (CDSMs) must meet for qualification including an opportunity for preliminary qualification for mechanisms still working toward full adherence, and established a process by which CDSMs may become qualified. The first list of [qualified CDSMs](#) was posted to the CMS website in conjunction with the CY 2018 proposed rule in July 2017.

In addition, CMS defined applicable payment systems under this program (MPFS, Hospital Outpatient Prospective Payment System (OPPS), and Ambulatory Surgical Center (ASC) payment system), specified the first list of priority clinical areas for the identification of outlier ordering professionals, and identified exceptions to the requirements that ordering professionals consults specified applicable AUC when ordering applicable imaging services.

The CY 2018 MPFS addressed the program implementation date and claims processing instructions for reporting AUC consultation. The 2018 final rule established a January 1, 2020 start date for Congressionally mandated AUC program for advanced diagnostic imaging services. On and after this date, ordering professionals must consult specified applicable AUC using a qualified CDSM when ordering applicable imaging services, and furnishing professionals must report AUC consultation information on the Medicare claim. The program will begin with a one year educational and operations testing period where claims will not be denied for errors in reporting the proper AUC consultation information. CMS also established a voluntary reporting period from July 2018 through the end of 2019 during which ordering professionals who are ready to participate in the AUC program may do so through the use of [modifier “QQ”](#). To incentivize early use of AUC consultation, CMS established in the Quality Payment Program (QPP) a high-weight improvement activity for ordering professionals who perform an AUC consultation using a qualified CDSM for the performance period that began on January 1, 2018.

The CY 2019 proposed rule proposes an addition to the definition of applicable setting, clarification around who may perform the required AUC consultation using a qualified CDSM under the program, clarification that reporting is required across claim types and by both the furnishing professional and furnishing facility, changes to the policy for significant hardship exceptions for ordering professionals under the program, mechanisms for claims-based reporting, and a request for feedback on the methodology to identify outlier ordering professionals.

Expanding Applicable Settings

Section 1834(q)(1)(D) of the Act specifies that the AUC consultation and reporting requirements apply only in an applicable setting, including a physician’s office, a hospital outpatient department (including an emergency department), an ambulatory surgical center, and “any other provider-led outpatient setting determined appropriate by the Secretary”. **CMS is proposing to revise the definition of applicable setting to include independent diagnostic testing facilities (IDTFs). CMS is soliciting comments on this proposal and on the possible inclusion of any other applicable setting.**

The agency believes that the addition of IDTFs to the definition of applicable setting will ensure that the AUC program is in place across outpatient settings in which outpatient advanced diagnostic imaging services are furnished and would appropriately and consistently apply the program. CMS also points out that the application of the AUC program is not only limited to applicable settings, but also to services for which payment is made under applicable payment systems (the MPFS, OPFS and ASC payment systems).

Consultations by Ordering Professionals

In response to comments in the 2018 rulemaking cycle seeking clarification on who is required to perform the consultation of AUC through a qualified CDSM, **CMS is proposing that the consultation may be performed by “auxiliary personnel incident to the ordering physician or non-physician practitioner’s professional service”**. While the specific proposal language states “auxiliary personnel”, the preamble language uses the phrase “clinical staff working under

the direction of the ordering professional, subject to applicable State licensure and scope of practice law”.

CMS recognizes that the statute does not explicitly provide for consultations under the AUC program to be fulfilled by other professionals, individuals or organizations on behalf of the ordering professional; however, the agency is making efforts to seek ways to minimize the burden of this new program. The rule notes that it is important to note that ordering professional is ultimately responsible for the consultation as their NPI is reported by the furnishing professional on the claim for the applicable imaging service and that it is the ordering professional who could be identified as an outlier ordering professional and become subject to prior authorization based on their ordering pattern.

Reporting AUC Consultation Information

When CMS initially codified the AUC consultation reporting requirement in through rulemaking in the CY 2018 PFS final rule, the agency specified only that “furnishing professionals” must report AUC consultation information on claims for applicable imaging services. This led some stakeholders to believe that AUC consultation information would be required only on practitioner claims. To better reflect the statutory requirements, **CMS is proposing to revise the regulations to clarify that AUC consultation information must be reported on all claims for an applicable imaging service furnished in an applicable setting and paid for under an applicable payment system (including both the professional and technical components).**

Claims-Based Reporting

In the CY 2018 MPFS proposed rule, CMS proposed using a combination of G-codes and modifiers to report the required AUC consultation information on the Medicare claim. In response to numerous public comments objecting to this potential solution, the agency considered additional approaches to reporting AUC information, including reporting of a unique consultation identifier (UCI) as suggested by the ACR as a less burdensome approach.

CMS had the opportunity to engage with stakeholders in the months since the publication of the CY 2018 MPFS final rule and understands that there are continued challenges with the UCI approach. The majority of solutions involving a UCI are claim-level solutions that do not allow attribution of the CDSM used or AUC adherence status to individual CPT codes for advanced diagnostic imaging services if more than one such code is included on a single claim. As such, CMS believes the approach of using a UCI would not identify whether an AUC consultation was performed for each applicable imaging service reported or be useful for the purposes of identifying outlier ordering professionals.

After exploring the UCI option, CMS concluded that it is not feasible to create a uniform UCI taxonomy, determine a location of the UCI on the claims form, obtain the support and permission by national bodies to use claim fields for this purpose, and solve the underlying issue that the UCI seems limited to claim-level reporting on time for the January 1, 2020 implementation date. Therefore, **CMS proposes to use code structures that are already in place (such as G-codes and modifiers) to establish reporting requirements, allowing for**

implementation to proceed on January 1, 2020. The agency will consider future opportunities to use a UCI and will continue to engage with stakeholders.

Under the proposal, each qualified CDSM would be assigned a G-code with a code descriptor containing the name of the qualified CDSM. If there is more than one advanced diagnostic imaging service on a claim, CMS could attribute a single G-code to all of the applicable imaging services on the claim, which would be appropriate if each AUC consultation for each service was through the same CDSM. If a different CDSM was used for each service (for example, when services on a single claim were ordered by more than one ordering professional and each ordering professional used a different CDSM) then multiple G-codes could be needed on the claim. Each G-code would appear on the claim individually as its own line item, which could result in confusion. As a potential solution, CMS considered the use of modifiers, which would appear on the same line as the CPT code that identifies the specific billed service.

Three modifiers would be developed to report the result of the AUC consultation as: 1) the imaging service would adhere to the applicable AUC, 2) the imaging service would not adhere to the criteria, or 3) such criteria were not applicable to the imaging service ordered. These modifiers, when placed on the same line with the CPT code for the advanced diagnostic imaging service, would allow the information to be easily accessed in the Medicare claims data and matched with the imaging service.

Significant Hardship Exception

CMS is proposing the following as situations where an ordering professional would not be required to consult AUC using a qualified CDSM when ordering advanced diagnostic imaging services:

- **Insufficient internet access;**
- **EHR or CDSM vendor issues (including temporary technical problems, installation or upgrades that impede access or CMS de-qualification of a CDSM vendor); or**
- **Extreme and uncontrollable circumstances (including natural or man-made disasters).**

The agency proposes that ordering professionals would self-attest if they are experiencing a significant hardship at the time of placing an advanced diagnostic imaging order and such attestation be supported with documentation of the significant hardship. Ordering professionals would communicate the information to the furnishing professional with the order and it would be reflected on the furnishing professional's and furnishing facility's claim by appending a HCPCS modifier. Claims that include the significant hardship modifier would not be required to include AUC consultation information.

In previous rulemaking, CMS proposed linking the significant hardship exceptions for the AUC program to other programs such as the EHR Incentive Program and/or MIPS. CMS believes that the current proposal is more straightforward and less burdensome, creating a process that is independent from other Medicare programs. The agency notes that the AUC program requires

provisions for real-time significant hardship exceptions rather than a complex process of applying for an exception.

CMS invites public comment on any additional circumstances that would cause the act of consulting AUC to be particularly difficult or challenging for the ordering professional.

The agency notes that circumstances such as the ordering professional being in clinical practice for a short period of time or having limited numbers of Medicare patients would not impede clinicians from consulting AUC as required by the program.

Identification of Outliers

CMS invites comments on a possible methodology for the identification of outlier ordering physicians who would eventually be subject to a prior authorization process when ordering advanced diagnostic imaging services. The agency is specifically seeking comments on the data elements and thresholds that CMS should consider when identifying outliers.

The proposed rule indicates that CMS does not intend to use data from the educational and operations testing period in CY 2020 in the analysis used to develop the outlier methodology. Therefore, the agency expects to address outlier identification and prior authorization more fully in CY 2022 or 2023 rulemaking.

Determination of Practice Expense (PE) Relative Value Units (RVUs) (Page 14)

Low volume services

For CY 2019, CMS is proposing to add 28 codes that have been identified as low volume services to the list of codes for which the expected specialty is assigned. Based on CMS' own medical review and input from the American Medical Association's Relative Value Scale Update Committee (RUC) and specialty societies, the agency is proposing to assign expected specialty codes as listed in Table 1 (below). Note that for these codes, only the professional code (PC) is nationally priced, whereas the global and technical components (TC) are priced by the Medicare Administrative Contractors (MACs).

TABLE 1: New Additions to Expected Specialty List for Low Volume Services

CPT Code	Mod	Short Descriptor	Expected Specialty	2017 Utilization
70557	26	Mri brain w/o dye	Diagnostic Radiology	126
70558	26	Mri brain w/dye	Diagnostic Radiology	32
74235	26	Remove esophagus obstruction	Gastroenterology	10
74301	26	X-rays at surgery add-on	Diagnostic Radiology	73
74355	26	X-ray guide intestinal tube	Diagnostic Radiology	11
74445	26	X-ray exam of penis	Urology	26
74742	26	X-ray fallopian tube	Diagnostic Radiology	5
74775	26	X-ray exam of perineum	Diagnostic Radiology	80
75801	26	Lymph vessel x-ray arm/leg	Diagnostic Radiology	114
75803	26	Lymph vessel x-ray arms/leg	Diagnostic Radiology	41
75805	26	Lymph vessel x-ray trunk	Diagnostic Radiology	50
75810	26	Vein x-ray spleen/liver	Diagnostic Radiology	46
76941	26	Echo guide for transfusion	Obstetrics/Gynecology	15
76945	26	Echo guide villus sampling	Obstetrics/Gynecology	31
76975	26	Gi endoscopic ultrasound	Gastroenterology	49
78282	26	Gi protein loss exam	Diagnostic Radiology	8
79300	26	Nuclr rx interstit colloid	Diagnostic Radiology	2
86327	26	Immunoelectrophoresis assay	Pathology	24
87164	26	Dark field examination	Pathology	30
88371	26	Protein western blot tissue	Pathology	2
93532	26	R & l heart cath congenital	Cardiology	28
93533	26	R & l heart cath congenital	Cardiology	36
93561	26	Cardiac output measurement	Cardiology	28
93562	26	Card output measure subsq	Cardiology	38
93616	26	Esophageal recording	Cardiology	38
93624	26	Electrophysiologic study	Cardiology	51
95966	26	Meg evoked single	Neurology	72
95967	26	Meg evoked each addl	Neurology	61

Equipment Maintenance

CMS notes that they continue to investigate potential avenues for determining equipment maintenance costs, but the rule does not contain any proposals on this topic.

Interest Rates

CMS does not make any proposed changes to the interest rates used in developing the equipment cost per minute calculation for CY 2019.

Changes to Direct PE Inputs for Specific Services

Standardization of Clinical Labor Tasks

Beginning with recommendations for CY 2019, the RUC has mandated the use of a new PE worksheet for their recommendation development process that standardizes the clinical labor

tasks and assigns them a clinical labor activity code. CMS believes the RUC's use of the new PE worksheet in developing and submitting recommendations will help simplify and standardize the hundreds of different clinical labor tasks currently listed in the direct PE database.

In reviewing the RUC-recommended direct PE inputs for CY 2019, CMS noticed that the 3 minutes of clinical labor time traditionally assigned to the "Prepare room, equipment and supplies" (CA013) clinical labor activity were split into 2 minutes for the "Prepare room, equipment and supplies" activity and 1 minute for the "Confirm order, protocol exam" (CA014) activity. These RUC-reviewed codes do not currently have clinical labor time assigned for the "Confirm order, protocol exam" clinical labor task, and CMS note that they do not have any reason to believe that the services being furnished by the clinical staff have changed, only the way in which this clinical labor time has been presented on the PE worksheets.

As a result, **CMS is proposing to maintain the 3 minutes of clinical labor time for the "Prepare room, equipment and supplies" activity and remove the clinical labor time for the "Confirm order, protocol exam" activity wherever this pattern was observed in the RUC recommended direct PE inputs.** If CMS had received RUC recommendations for codes that currently include clinical labor time for the "Confirm order, protocol exam" clinical labor task, they would have left the recommended clinical labor times unchanged, but there were no such codes reviewed for CY 2019. The agency notes that there is no effect on the total clinical labor direct costs in these situations, since the same 3 minutes of clinical labor time is still being used in the calculation of PE RVUs.

Equipment Recommendations for Scope Systems (Page 36)

Since the RUC has convened a Scope Equipment Reorganization Workgroup that will make recommendations to CMS on scope organization and scope pricing, the agency is proposing to delay any further changes to scope equipment until CY 2020.

Technical Corrections to Direct PE Input Database and Supporting Files (Page 42)

CMS is proposing to correct several clerical inconsistencies in the direct PE database. The database is available for download on the [CMS website](#).

Updates to Prices for Existing Direct PE Inputs (Page 48)

CMS initiated a market research contract with StrategyGen to conduct an in-depth and robust market research study to update the MPFS direct PE inputs (DPEI) for supply and equipment pricing for CY 2019. StrategyGen has submitted a report with updated pricing recommendations for approximately 1,300 supplies and 750 equipment items currently used as direct PE inputs. This report is available on the [CMS website](#) under downloads for the CY 2019 MPFS.

Resources and methodologies used by StrategyGen in their market research study of the supply and equipment items included field surveys, aggregate databases, vendor resources, market scans, market analysis, physician substantiation, and statistical analysis to estimate and validate current prices for medical equipment and medical supplies. StrategyGen also conducted

secondary market research on each of the 2,072 DPEI medical equipment and supply items that CMS identified from the current DPEI database.

StrategyGen developed the preliminary Recommended Price (RP) methodology based on the following rules in hierarchical order considering both data representativeness and reliability:

1. If the market share, as well as the sample size, for the top three commercial products were available, the weighted average price (weighted by percent market share) was the reported RP. Commercial price, as a weighted average of market share, represents a more robust estimate for each piece of equipment and a more precise reference for the RP.
2. If StrategyGen did not have market share for commercial products, then they used a weighted average (weighted by sample size) of the commercial price and General Services Administration (GSA) price for the RP. The impact of the GSA price may be nominal in some of these cases since it is proportionate to the commercial samples sizes.
3. Otherwise, if single price points existed from alternate supplier sites, the RP was the weighted average of the commercial price and the GSA price.
4. Finally, if no data were available for commercial products, the GSA average price was used as the RP; and when StrategyGen could find no market research for a particular piece of equipment or supply item, the current CMS prices were used as the RP.

StrategyGen found that despite technological advancements, the average commercial price for medical equipment and supplies has remained relatively consistent with the current CMS price. However, while there were no statistically significant differences in pricing at the aggregate level, medical specialties will experience increases or decreases in their Medicare payments if CMS were to adopt the pricing updates recommended by StrategyGen. At the service level, there may be large shifts in PE RVUs for individual codes that happened to contain supplies and/or equipment with major changes in pricing. CMS notes that codes with a sizable PE RVU decrease would be limited by the requirement to phase in significant reductions in RVUs. The phase-in requirement limits the maximum RVU reduction for codes that are not new and revised to 19 percent in any individual calendar year.

CMS is proposing to adopt the updates direct PE input prices for supplies and equipment as recommended by StrategyGen. Given the potentially significant changes in payment that would occur, both for specific services and more broadly at the specialty level, the agency is proposing to phase in use of the new direct PE input pricing over a 4-year period using a 25/75 (CY 2019), 50/50 percent (CY 2020), 75/25 percent (CY 2021) and 100/0 percent (CY 2022) split between new and old pricing. CMS notes that this transition period will not only ease the shift to the updated supply and equipment pricing, but will allow interested parties an opportunity to review and respond to the new pricing information associated with their services.

TABLE 7: Example of Direct PE Pricing Transition

Current Price	\$100	
Final Price	\$200	
Year 1 (CY 2019) Price	\$125	1/4 difference between \$100 and \$200
Year 2 (CY 2020) Price	\$150	1/3 difference between \$125 and \$200
Year 3 (CY 2021) Price	\$175	1/2 difference between \$150 and \$200
Final (CY 2022) Price	\$200	

For new supply and equipment codes for which CMS establishes prices during the transition years based on the public submission of invoices, CMS is proposing to fully implement those prices with no transition since there are no current prices for these supply and equipment items. The agency is also proposing that for existing supply and equipment codes, when prices are established based on invoices that are submitted as part of a revaluation or comprehensive review of a code or code family, they will be fully implemented for the year they are adopted without being phased in.

For existing supply and equipment codes that are not part of a comprehensive review and valuation of a code family and for which CMS establishes prices based on invoices submitted by the public, the agency is proposing to implement the established invoice price as the updated price and to phase in the new price over the remaining years of the proposed 4-year pricing transition. During the proposed transition period, where price changes for supplies and equipment are adopted without a formal review of the HCPCS codes that include them, CMS believes it is important to include them in the remaining transition toward the updated price. The agency is also proposing to phase in any updated pricing established during the 4-year transition period for very commonly used supplies and equipment that are included in 100 or more codes, such as sterile gloves (SB024) or exam tables (EF023), even if invoices are provided as part of the formal review of a code family. The new prices would be implemented for any such supplies and equipment over the remaining years of the proposed 4-year transition period. The proposal is intended to minimize any potential disruptive effects during the proposed transition period that could be caused by other sudden shifts in RVUs due to the high number of services that make use of these very common supply and equipment items.

CMS notes that the phase-in will allow more opportunities for public comment and submission of additional, applicable data. The agency welcomes feedback from stakeholders on the proposed updated supply and equipment pricing, including the submission of additional invoices for consideration.

To maintain relativity between the clinical labor, supplies, and equipment portions of the PE methodology, CMS believes that the rates for the clinical labor staff should also be updated along with the updated pricing for supplies and equipment. **The agency seeks public comment regarding whether to update the clinical labor wages used in developing PE RVUs in future calendar years during the 4-year pricing transition for supplies and equipment, or whether it would be more appropriate to update the clinical labor wages at a later date following the**

conclusion of the transition for supplies and equipment, for example, to avoid other potentially large shifts in PE RVUs during the 4-year pricing transition period.

Breast Biopsy software (EQ370) (Page 54)

After the publication of the CY 2018 MPFS final rule, a stakeholder contacted CMS to request that the price for the Breast Biopsy software (EQ370) equipment be updated. This equipment item currently lacks a price in the direct PE database, and when an invoice for the Breast Biopsy software was first submitted during the CY 2014 MPFS rule, CMS stated that this item served clinical functions similar to other items already included in the Magnetic Resonance (MR) room equipment package (EL008). Therefore, CMS did not create new direct PE inputs for this equipment item.

The stakeholder suggested that this software is used to subtract the imaging raw data series from the MRI Scanner, reformat the images in multiple planes to allow accurate targeting of the lesion to be biopsied, identify the location of a fiducial marker on the patient's skin, and then target the location of the enhancing lesion to be biopsied. The stakeholder requested that EQ370 be renamed as "Breast MRI computer aided detection and biopsy guidance software" and added to the following CPT codes:

- 19085 (Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; first lesion, including magnetic resonance guidance)
- 19086 (Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including magnetic resonance guidance)
- 19287 (Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; first lesion, including magnetic resonance guidance)
- 19288 (Placement of breast localization device(s) (eg clip, metallic pellet, wire/needle, radioactive seeds), percutaneous; each additional lesion, including magnetic resonance guidance)
- 77X51 (Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD- real time lesion detection, characterization and pharmacokinetic analysis) when performed; unilateral)
- 77X52 (Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD- real time lesion detection, characterization and pharmacokinetic analysis) when performed; bilateral)

An invoice with a purchase price of \$52,275 was supplied to CMS.

After reviewing the use of the Breast Biopsy software (EQ370) equipment in these six codes, CMS is not proposing to update the price or add the software to these procedures. The agency continues to believe that equipment item EQ370 serves clinical functions similar to other items already included in the MR room equipment package (EL008), and that it would be duplicative to include this Breast Biopsy software as a separate direct PE input. CMS also notes that the RUC recommendations for the new CPT codes 77X51 and

77X52 do not include EQ370 in the recommended equipment for these procedures and they do not have any reason to believe that the inclusion of additional Breast Biopsy software beyond what is already contained in the MR room equipment package would be typical. CMS will however, update the name of the EQ370 equipment item from “Breast Biopsy software” to the requested “Breast MRI computer aided detection and biopsy guidance software” to help better describe the equipment in question.

Determination of Malpractice (MP) RVUs (Page 58)

In the CY 2018 MPFS proposed rule, CMS proposed to use the updated MP data to update the specialty risk factors used in calculation of the MP RVUs prior to the next 5-year update (CY 2020). However, in the CY 2018 MPFS final rule, after consideration of the comments received and some differences observed in the descriptions on the raw rate filings as compared to how those data were categorized to conform with the CMS specialties, CMS did not finalize the proposal to use the updated MP data.

CMS is seeking additional comment regarding the next MP RVU update which must occur by CY 2020. The agency is specifically seeking comment on how they might improve the way that specialties in the state-level raw rate filings data are crosswalked for categorization into CMS specialty codes which are used to develop the specialty-level risk factors and the MP RVUs.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services (Page 61)

CMS notes that in recent years, they have sought to recognize significant changes in health care practice, especially innovations in the active management and ongoing care of chronically ill patients. After considering comments received in response to the CY 2018 MPFS proposed rule, the agency has come to believe that statutory limitations for Medicare telehealth services do not apply to all kinds of physicians’ services whereby a medical professional interacts with a patient via remote communication technology. Rather, CMS believes that these restrictions apply only to services that are defined, coded and paid for as if they were furnished during an in-person encounter between a patient and a health care professional. As such, CMS is proposing several concepts for increasing Medicare patients’ access to physicians’ services that are routinely furnished via communication technology.

Brief Communication Technology-Based Service

Beginning January 1, 2019, CMS is proposing to pay separately for a newly defined type of physicians’ service furnished using communication technology. This service, GVC11 (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can 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) would be

billable when a physician or other qualified health care professional has a brief non-face-to-face check-in with a patient via communication technology, to assess whether the patient's condition necessitates an office visit. This service would be priced at a rate lower than existing E/M in-person visits. The agency is seeking comment on what types of communication technology are utilized by health care professionals in furnishing these services, including whether audio-only telephone interactions are sufficient compared to interactions that are enhanced with video or other kinds of data transmission.

Remote Evaluation of Pre-Recorded Patient Information

CMS is proposing to create, effective January 1, 2019 code 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) that describes the remote professional evaluation of patient-transmitted information conducted via pre-recorded "store and forward" video or image technology. As with the previous proposal, these services may be used to determine whether or not an office visit or other service is warranted. When the information review results in an in-person E/M office visit with the same physician or health care professional, CMS proposes that this remote service would be considered bundled into that office visit.

Interprofessional Internet Consultation

In 2013, CMS received RUC recommendations for valuation of the following CPT codes:

- 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)
- 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)
- 99448 (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; 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)

CMS declined to make separate payment, stating in the CY 2014 MPFS final rule with comment period that these kinds of services are considered bundled.

For CY 2019, the CPT Editorial Panel created two new codes to describe additional consultative services, including a code describing the work of the treating physician when initiating a consult, and the RUC recommended valuation for new codes, CPT codes 994X0 (Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes) and 994X6 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's creating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time). The RUC also resubmitted the prior recommendations for the existing CPT codes.

CMS now believes that proposing payment for these interprofessional consultations performed via communications technology such as telephone or internet is consistent with ongoing efforts to recognize and reflect medical practice trends in primary care and patient-centered management within the MPFS.

While CMS is proposing to make separate payment for these services because they believe the resource costs may be directly associated with seeking a consultation for the benefit of the beneficiary, the agency has concerns about how these services can be distinguished from activities undertaken for the benefit of the practitioner, such as information shared as a professional courtesy or as continuing education. CMS does not believe that those examples would constitute a service directly attributable to a single Medicare beneficiary, and therefore neither the Medicare program nor the beneficiary should be responsible for those costs. **CMS is seeking comment on the assumption that these are separately identifiable services, and the extent to which they can be distinguished from similar services that are nonetheless primarily for the benefit of the practitioner.**

CMS notes that there are program integrity concerns around making separate payment for these interprofessional consultation services, including around CMS' or its contractors' ability to evaluate whether an interprofessional consultation is reasonable and necessary under the particular circumstances. **CMS is seeking comment on how best to minimize potential program integrity issues, and are particularly interested in information on 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.**

Additionally, since these codes describe services that are furnished without the beneficiary being present, CMS is proposing to require the treating practitioner to obtain verbal beneficiary consent in advance of these services, which would be documented by the treating practitioner in the medical record, similar to the conditions of payment associated with the care management services under the MPFS. Obtaining advance consent includes ensuring that the patient is aware of applicable cost sharing. CMS welcomes comments on this proposal.

Requests to Add Services to the Approved List of Medicare Telehealth Services

Historically, requests to add services to the list of Medicare telehealth services had to be submitted and received no later than December 31 of each calendar year to be considered for the next rulemaking cycle. **For CY 2019 and onward, CMS intends to accept requests through February 10th, consistent with the deadline for receipt of code valuation recommendations from the RUC.**

CMS is proposing to add HCPCS codes G0513 and G0514 (Prolonged preventive services) to the list of Medicare telehealth services. The agency also received requests to add codes for chronic care remote physiologic monitoring, interprofessional internet consultation, and initial hospital care; or to change the requirements for subsequent hospital care or subsequent nursing facility care.

Potentially Misvalued Services (Page 93)

Since CY 2009, as part of the annual potentially misvalued code review and Five-Year Review process, CMS has reviewed approximately 1,700 potentially misvalued codes to refine work relative value units (RVUs) and direct practice expense (PE) inputs.

Public Nominations

For CY 2019, CMS received one submission that nominated several high-volume codes for review under the potentially misvalued code initiative. In the request, the submitter noted a “systemic overvaluation” of work RVUs in certain procedures and tests based “on a number of Government Accountability Office (GAO) and the Medicare Payment Advisory Commission (MedPAC) reports, media reports regarding time inflation of specific services, and the January 19, 2017 Urban Institute report for CMS.” The submitter suggested that the times CMS assumes in estimating work RVUs are inaccurate for procedures, especially due to substantial overestimates of preservice and postservice time, including follow-up inpatient and outpatient visits that do not take place. According to the submitter, the time estimates for tests and some other procedures are primarily overstated as part of the intraservice time. Furthermore, the submitter stated that previous RUC reviews of these services did not result in reductions in valuation that adequately reflected reductions in surveyed times. The submitter requested that the codes in the below Table 8 be reviewed as potentially misvalued.

TABLE 8: Public Nominations Due to Overvaluation

CPT Code	Short Description
27130	Total hip arthroplasty
27447	Total knee arthroplasty
43239	Egd biopsy single/multiple
45385	Colonoscopy w/lesion removal
70450	CT head w/o contrast
93000	Electrocardiogram complete
93306	Tte w/doppler complete

Update on the Global Surgery Data Collection

Beginning July 1, 2017, CMS required practitioners in groups with 10 or more practitioners in nine states (Florida, Kentucky, Louisiana, Nevada, New Jersey, North Dakota, Ohio, Oregon, and Rhode Island) to use the no-pay CPT code 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an E/M service was performed during a postoperative period for a reason(s) related to the original procedure) to report postoperative visits. Practitioners who only practice in practices with fewer than 10 practitioners are exempted from required reporting, but are encouraged to report if feasible.

CMS reports results from the first six months of data collection in this proposed rule. In the nine states, from July 1, 2017 through December 31, 2017, there were 990,581 postoperative visits reported using CPT code 99024 (Postoperative follow-up visit, normally included in the surgical package, to indicate that an E/M service was performed during a postoperative period for a reason(s) related to the original procedure). Of the 32,573 practitioners who furnished at least one of the 293 applicable procedures during this period and who, based on Tax Identification Numbers in claims data, were likely to meet the practice size threshold, only 45 percent reported one or more visit using CPT code 99024 during this 6-month period. The share of practitioners who reported any CPT code 99024 claims varied by specialty. Among surgical oncology, hand CMS-1693-P 102 surgery, and orthopedic surgeons, reporting rates were 92, 90, and 87 percent, respectively. In contrast, the reporting rate for emergency medicine physicians was 4 percent.

CMS is seeking comment on how to encourage reporting to ensure the validity of the data without imposing undue burden. The agency is also asking for comment on whether or not it is reasonable to assume that many visits included in the valuation of 10-day global packages are not being furnished or whether there are alternative explanations for what could be a significant underreporting of postoperative visits. Finally, CMS is seeking comment on whether they should consider changing the global period for the 10-day global codes and reviewing the code valuation.

Radiologist Assistants (Page 111)

In response to the Request for Information (RFI) on CMS Flexibilities and Efficiencies that was issued in the CY 2018 MPFS proposed rule, many commenters recommended that the physician supervision requirements for diagnostic tests typically furnished by a radiologist assistant (RA) under the supervision of a physician be revised from personal supervision to direct supervision. The commenters indicated that the current supervision requirements for certain diagnostic imaging services unduly restrict RAs from conducting tests that they are permitted to do under current law in many states.

After consideration of the comments, **CMS is proposing to revise the supervision requirements to specify that all diagnostic imaging tests may be furnished under the direct supervision of a physician when performed by an RA in accordance with state law and state scope of practice rules.** Specifically, CMS is proposing to revise the regulations to add a new paragraph to state that diagnostic tests performed by a registered radiologist assistant (RRA)

or a radiology practitioner assistant (RPA) require only a direct level of supervision, when permitted by state law and state scope of practice regulations. The agency notes that for diagnostic imaging tests requiring general level of supervision, this proposal would not change the level of physician supervision to direct supervision.

In considering comments received by stakeholders on this issue, CMS took into consideration information on the education and clinical experience of RAs and determined that the proposal would not pose a significant risk to patient safety. Additionally, CMS recognizes that 28 states have statutes or regulations that recognize RAs and these states have general or direct supervisions requirements for RAs.

Payment Rates under the MPFS for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based Department of a Hospital (Page 113)

Sections 1833(t)(1)(B)(v) and (t)(21) of the Act require that certain items and services furnished by certain off-campus provider-based departments (PBDs) (collectively referenced in this rule as nonexcepted items and services furnished by nonexcepted off-campus PBDs) shall not be considered covered outpatient department (OPD) services for purposes of payment under the OPSS. Payment for these nonexcepted items and services furnished on or after January 1, 2017 shall be made under the applicable payment system. In the CY 2017 OPSS/ASC final rule with comment period, CMS finalized the MPFS as the “applicable payment system” for most nonexcepted items and services furnished by off-campus PBDs.

In the CY 2017 interim final rule, CMS established site-specific rates under the MPFS for the technical component of the broad range of nonexcepted items and services furnished by nonexcepted off-campus PBDs to be paid under the MPFS that was based on the OPSS payment amount for the same items and services, scaled downward by 50 percent. CMS called this adjustment the “PFS Relativity Adjuster.” The PFS Relativity Adjuster refers to the percentage of the OPSS payment amount paid under the MPFS for a nonexcepted item or service to the non-excepted off-campus PBD under this policy. For CY 2018, the PFS Relativity Adjuster was changed to 40 percent.

For CY 2019, CMS is proposing to continue to allow nonexcepted off-campus PBDs to bill for nonexcepted items and services on an institutional claim using a “PN” modifier until an alternative workable mechanism is developed that would improve payment accuracy.

CMS notes that they had access to a full year of claims data from CY 2017 for services submitted with the “PN” modifier. After a detailed analysis, the agency found that the data supports maintaining the PFS Relativity Adjuster of 40 percent. CMS proposes to maintain this PFS Relativity Adjuster for future years until updated data or other considerations indicate that an alternative adjuster or a change to the approach is warranted.

Valuation of Specific Codes (Page 128)

Fine Needle Aspiration (CPT codes 10021, 10X11, 10X12, 10X13, 10X14, 10X15, 10X16, 10X17, 10X18, 10X19, 76492, 77002 and 77021) (Page 143)

The CPT Editorial Panel was asked to review CPT codes 10021 and 10022 to bundle with imaging guidance. The Panel deleted CPT code 10022, revised CPT code 10021, and also created nine new codes to describe fine needle aspiration with and without imaging guidance. CMS is proposing to accept the RUC-recommended values for seven of the ten codes: 0.80 RVU for CPT code 10X11, 1.00 RVU for CPT code 10X13, 1.81 RVUs for CPT code 10X14, 1.18 RVUs for CPT code 10X15, 1.65 RVUs for CPT code 10X17, and contractor pricing for CPT codes 10X18 and 10X19. CMS is also proposing the RUC-recommended 1.50 RVUs for CPT code 77021, and also to reaffirm the current values for CPT codes 76942 and 77002 at 0.67 RVU and 0.54 RVU, respectively.

CMS, uncomfortable with the disproportional decrease between total time and work RVU, disagreed with the RUC-recommended value for CPT code 10021. Instead, CMS is proposing a work RVU of 1.03 based on a direct crosswalk to CPT code 36440, which has the same intra-service time and similar total time.

CMS is proposing 1.46 RVUs for CPT 10X12, maintaining the RUC-recommended 0.43 RVU increment between 10021 and 10X12, but building on the CMS-proposed 1.03 RVU for 10021. CPT codes 99225 and 99232 are referenced as crosswalks.

CMS is proposing 2.26 RVUs for CPT 10X16, maintaining the RUC-recommended 1.23 RVU increment between 10021 and 10X16, but building on the CMS-proposed 1.03 RVU for 10021. CPT code 74263 is referenced as a crosswalk.

Knee Arthrography Injection (CPT code 27X69) (Page 153)

Due to growing concern about CPT code 27370 likely being incorrectly used to report arthrocentesis or aspiration, the CPT Editorial Panel created CPT code 27X69 to replace it, revising the descriptor to clarify that it should be used to report an injection procedure for knee arthrography or enhanced CT/MRI knee arthrography.

While the RUC recommended 0.96 RVU, identical to 27370, CMS cited the decrease in physician time for CPT code 27X69 and is proposing a work RVU of 0.77. CMS supports this recommendation with a crosswalk to CPT code 29075.

PICC Line Procedures (CPT codes 36568, 36569, 36X72, 36X73, and 36584) (Page 161)

The CPT Editorial panel revised CPT codes 36568, 36569, and 36584, and also created two new codes, 36X72 and 36X73 to report the insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion.

CMS agrees with the RUC-recommended work RVUs of 2.11 for CPT code 36568 and 1.90 for CPT code 36569.

At the RUC-recommended 2.00 RVUs for CPT code 36X72, CMS expressed some concerns about rank order issues with other codes in the family, specifically 36568 and 36569. CMS is proposing 1.82 RVUs for CPT code 36X72 based on a direct crosswalk to CPT code 50435. CMS also cites three additional crosswalks: CPT codes 32554, 43198, and 64644, which all have similar intensity, intra-service and total times, and 1.82 RVUs.

CMS is proposing 1.70 RVUs for CPT code 36X73, a decrease from the RUC-recommended 1.90 RVUs. CPT codes 36X73 and 36569 describe the same procedure, with 36X73 involving imaging guidance and 36569 being performed without imaging guidance. In comparing CPT code 36X73 to CPT code 36569 (proposed 1.90 RVU), CMS noted that 36X73 required less time, and therefore, is recommending 1.70 RVUs, the current value for 36569.

CMS is proposing to maintain the current work RVU of 1.20 for CPT code 36584. Noting that the physician time has decreased, CMS cannot justify the RUC-recommended increase in work RVU to 1.47. CPT code 40490 is referenced as a crosswalk.

Radioactive Tracer (CPT code 38792) (Page 167)

CMS is proposing to accept the RUC-recommended 0.65 RVU for CPT code 38792, an increase over the current value.

Dilation of Urinary Tract (CPT codes 50X39, 50X40, 52334, and 74485) (Page 172)

CPT code 50395 was referred to CPT to clarify any overlap in physician work with CPT code 50432, resulting in the deletion of CPT code 50395 and the creation of two new codes, 50X39 and 50X40, to report dilation of an existing tract and establishment of new access to the collecting system, including percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy), all associated radiological supervision and interpretation, as well as post procedure tube placement when performed.

The RUC recommended 3.37 RVU for 50X39, identical to the RVU of the deleted code (which didn't include the newly bundled imaging guidance). However, citing the decrease in physician time, CMS disagreed with the RUC-recommended value for CPT code 50X39 and is proposing a decrease to 2.78 RVUs, supported by a crosswalk to CPT code 31646 and comparisons to the two reference codes, 50694 and 50695.

CMS refined the RUC-recommended intra-service time and work RVU for CPT code 50X40. CMS reduced the RUC-recommended 60 minutes of intra-service time to 45 minutes, which is the median survey time. With the reduction in time, CMS feels that the RUC-recommended work RVU of 5.25 is overstated, and is recommending a decreased value of 4.83 RVUs. CMS reached this value by applying the 2.07 RVUs incremental increase between the RUC-recommended

values for 50X39 and 50X40. CPT code 36902 is referenced as a reasonable crosswalk to support the 4.83s RVU recommendation.

CMS is proposing to accept the RUC-recommended 3.37 RVUs for CPT code 52334 and 0.83 RVU for CPT code 74485.

X-Ray Spine (CPT codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, and 72120) (Page 185)

The RUC approved the use of a “crosswalk methodology” by the specialty societies to value the twelve x-ray spine codes by comparing them to similar x-ray CPT codes. An additional eight x-ray codes, including the toe, heel, sacrum, sacroiliac joints, elbow, and forearm, were also valued using this methodology. However, CMS expressed concerns about the lack of survey data to support the RUC recommendations, stating that there is no new information about efficiencies or changes in time and intensity due to changes in practice patterns.

In lieu of accepting the RUC recommendations, CMS proposed an alternative methodology which involved calculating the utilization-weighted average of the RUC-recommended work RVUs to value all twenty crosswalked codes. This resulted in the recommendation of 0.23 RVU for all twenty of the crosswalked codes, which range from 5-8 minutes total time.

X-Ray Sacrum (CPT codes 72200, 72202, and 72220) (Page 189)

The RUC approved the use of a “crosswalk methodology” by the specialty societies to value the three x-ray sacrum codes, along with seventeen additional x-ray codes, by comparing them to other similar x-ray CPT codes. However, CMS expressed concerns about the lack of survey data to support the RUC recommendations, stating that there is no new information about efficiencies or changes in time and intensity due to changes in practice patterns.

In lieu of accepting the RUC recommendations, CMS proposed an alternative methodology which involved calculating the utilization-weighted average of the RUC-recommended work RVUs to value all twenty crosswalked codes. This resulted in the recommendation of 0.23 RVU for all twenty of the crosswalked codes, which range from 5-8 minutes total time.

X-Ray Elbow-Forearm (CPT codes 73070, 73080, and 73090) (Page 189)

The RUC approved the use of a “crosswalk methodology” by the specialty societies to value the three x-ray elbow-forearm codes, along with seventeen additional x-ray codes, by comparing them to other similar x-ray CPT codes. However, CMS expressed concerns about the lack of survey data to support the RUC recommendations, stating that there is no new information about efficiencies or changes in time and intensity due to changes in practice patterns.

In lieu of accepting the RUC recommendations, CMS proposed an alternative methodology which involved calculating the utilization-weighted average of the RUC-recommended work RVUs to value all twenty crosswalked codes. This resulted in the recommendation of 0.23 RVU for all twenty of the crosswalked codes, which range from 5-8 minutes total time.

X-Ray Heel (CPT code 73650) (Page 190)

The RUC approved the use of a “crosswalk methodology” by the specialty societies to value the x-ray heel code, along with nineteen additional x-ray codes, by comparing them to other similar x-ray CPT codes. However, CMS expressed concerns about the lack of survey data to support the RUC recommendations, stating that there is no new information about efficiencies or changes in time and intensity due to changes in practice patterns.

In lieu of accepting the RUC recommendations, CMS proposed an alternative methodology which involved calculating the utilization-weighted average of the RUC-recommended work RVUs to value all twenty crosswalked codes. This resulted in the recommendation of 0.23 RVU for all twenty of the crosswalked codes, which range from 5-8 minutes total time.

X-Ray Toe (CPT code 73660) (Page 190)

The RUC approved the use of a “crosswalk methodology” by the specialty societies to value the x-ray toe code, along with nineteen additional x-ray codes, by comparing them to other similar x-ray CPT codes. However, CMS expressed concerns about the lack of survey data to support the RUC recommendations, stating that there is no new information about efficiencies or changes in time and intensity due to changes in practice patterns.

In lieu of accepting the RUC recommendations, CMS proposed an alternative methodology which involved calculating the utilization-weighted average of the RUC-recommended work RVUs to value all twenty crosswalked codes. This resulted in the recommendation of 0.23 RVU for all twenty of the crosswalked codes, which range from 5-8 minutes total time.

X-Ray Esophagus (CPT codes 74210, 74220, 74230) (Page 190)

CMS is proposing to accept the RUC-recommendations for the three x-ray esophagus codes: 0.59 RVU for CPT code 74210, 0.67 RVU for CPT code 74220, and 0.53 RVU for CPT code 74230.

CMS is seeking comment on the typical use of Polibar barium suspension for these procedures, citing the increase in quantity for CPT code 74210 and the addition to CPT code 74220.

X-Ray Urinary Tract (CPT code 74420) (Page 191)

CMS is proposing to accept the RUC-recommendation of 0.52 RVU for CPT code 74420.

Fluoroscopy (CPT code 76000) (Page 192)

CMS is proposing to accept the RUC-recommendation of 0.30 RVU for CPT code 76000.

Ultrasound Elastography (CPT codes 767X1, 767X2, and 767X3) (Page 194)

CMS is proposing to accept the RUC-recommendations for the three ultrasound elastography codes used to assess organ parenchyma and focal lesions: 0.59 RVU for CPT code 767X1, 0.59 RVU for CPT code 767X2, and 0.50 RVU for CPT code 767X3.

Ultrasound Exam - Scrotum (CPT code 76870) (Page 195)

CMS is proposing to accept the RUC-recommendation of 0.64 RVU for CPT code 76870.

Contrast-Enhanced Ultrasound (CPT codes 76X0X and 76X1X) (Page 196)

The CPT Editorial Panel created two new codes to describe the new technology of using intravenous microbubble agents to evaluate lesions by ultrasound.

CMS does not agree with the RUC recommendation of 1.62 RVUs for CPT code 76X0X, which was valued by crosswalking to CPT code 73719. CMS is uncomfortable with this methodology because it did not rely on the survey 25th or median RVU value. Therefore, CMS refined the RUC recommendation to the survey 25th percentile of 1.27 RVUs, citing CPT codes 93975 and 72270 as supporting reference codes.

CMS is proposing to accept the RUC-recommendation of 0.85 RVU for CPT code 76X1X.

Magnetic Resonance Elastography (CPT code 76X01) (Page 198)

The CPT Editorial Panel created CPT code 76X01 to describe the use of magnetic resonance elastography to evaluate organ parenchymal pathology.

CMS does not agree with RUC-recommended 1.29 RVUs for CPT code 76X01, citing concerns about relativity compared to other imaging codes similar intraservice times. Using the intraservice-time ratio and the two key reference service codes, 74183 and 74181, CMS is proposing 1.10 RVUs for 76X01. They are supporting this value with a direct crosswalk to CPT code 71250.

Computed Tomography (CT) Scan for Needle Biopsy (CPT code 77012) (Page 200)

CMS is proposing to accept the RUC-recommendation of 1.50 RVUs for CPT code 77012.

CMS is proposing to refine the practice expense CT room time, stating that there has been a longstanding convention to assign nine minutes to the equipment room for radiological supervision and interpretation procedures. CMS indicates that will maintain relativity with 38 other codes until all of the codes can be subject to further review.

Dual-Energy X-Ray Absorptiometry (CPT code 77081) (Page 201)

CMS is proposing to accept the RUC-recommendation of 0.20 RVU for CPT code 77081.

Breast MRI with Computer-Aided Detection (CPT codes 77X49, 77X50, 77X51, and 77X52)
(Page 202)

The CPT Editorial Panel deleted breast MRI codes 77058 and 77059 and created four new codes for breast MRI with and without contrast (including CAD), 77X49, 77X50, 77X51, and 77X52.

CMS is proposing to refine the RUC-recommended value for CPT code 77X49 from 1.45 RVUs to 1.15 RVUs, based on the time ratio between 77X49 and the deleted code it is replacing, 77058. CMS expressed some concerns that the reduction in total time was not adequately reflected in the 1.45 RVUs recommendation. CMS references CPT code 77334 as a crosswalk code to support the 1.15 RVUs recommendation.

While CPT code 77X49 describes unilateral breast MRI without contrast, CPT code 77X50 describes the same procedure, but bilateral. For this reason, CMS proposes to maintain the 0.15 RVU increment between the RUC-recommended values for 77X49 and 77X50. Therefore, CMS is proposing 1.30 RVUs for 77X50.

CPT code 77X51 bundles unilateral breast MRI (with or without contrast) with CAD. CMS proposes to maintain the 0.65 RVU increment between the RUC-recommended values for 77X49 and 77X51. Therefore, CMS is proposing 1.80 RVUs for 77X51.

CPT code 77X52 bundles bilateral breast MRI (with or without contrast) with CAD. CMS proposes to maintain the 0.85 RVU increment between the RUC-recommended values for 77X49 and 77X52. Therefore, CMS is proposing 2.00 RVUs for 77X52.

CMS indicates that they did not receive invoices for five new practice expense equipment items.

Evaluation and Management (E/M) Visits (Page 322)

Potential misevaluation of E/M codes is an issue that CMS has been considering for several years. The agency notes that this code set represents a high proportion of MPFS expenditures, but has not been recently revalued to account for significant changes in the disease burden of the Medicare patient population and changes in health care practice that are underway to meet the Medicare population's health care needs.

Stakeholders have long maintained that all of the E/M documentation guidelines are administratively burdensome and outdated with respect to the practice of medicine. Feedback has indicated that the guidelines are too complex, ambiguous, fail to meaningfully distinguish differences among code levels and are not updated for changes in technology, especially electronic health record use. Prior attempts to revise the E/M guidelines were unsuccessful or resulted in additional complexity due to lack of stakeholder consensus and differing perspectives on whether code revaluation would be necessary under the MPFS as a result of revising the guidelines.

Having considered public feedback to the CY 2018 MPFS proposed rule and other outreach efforts, CMS is proposing several changes to E/M visit documentation and payment. The proposed changes would only apply to office/outpatient visit codes except where otherwise specified.

Eliminating Extra Documentation Requirements for Home Visits

CMS is proposing to remove the requirement that the medical record must document the medical necessity of furnishing the visit in the home rather than in the office. CMS welcomes public comment on this proposal, including any potential unintended consequences of eliminating the requirement.

Public Comment Solicitation on Eliminating Prohibition on Billing Same-Day Visits

Currently, the Medicare Claims Processing Manual states that two E/M office visits billed by a physician or physician of the same specialty from the same practice for the same beneficiary on the same day may not be reimbursed unless the physician documents that the visits were for unrelated problems. CMS has received comments from stakeholders indicating that it is increasingly common for practitioners to have multiple specialty affiliations but would have only one primary Medicare enrollment specialty. As such, it is not uncommon for patients to see more than one physician in a practice on the same day.

CMS is soliciting public comment on whether the manual provision should be eliminated given the changes in the practice of medicine or whether there is concern that eliminating it might have unintended consequences for practitioners and beneficiaries.

Providing Choices in Documentation – Medical Decision-Making, Time or Current Framework

CMS proposes to allow practitioners to choose, as an alternative to the current documentation framework, either medical decision-making or time as a basis to determine the appropriate level of E/M visit. This proposal would allow different practitioners in different specialties to choose to document the factor(s) that matter most given the nature of their clinical practice.

In addition, the agency is proposing a single payment amount for office/outpatient E/M visit levels 2 through 5 and a minimum documentation standard where practitioners would only need to meet documentation requirements currently associated with a level 2 visit for history, exam and/or medical decision-making. CMS notes that practitioners could choose to document more information for clinical, legal, operational or other purposes.

CMS is proposing that practitioners would be required to document that the typical time required for the base or “companion” visit is exceeded by the amount required to report prolonged services when a practitioner chooses to document using time and also reports prolonged E/M services.

The agency's primary goal with these proposals is to reduce administrative burden and allow practitioners to focus on the patient.

Removing Redundancy in E/M Visit Documentation

CMS is proposing that practitioners only be required to focus 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. Additionally, the agency proposes that for both new and established patients, practitioners would no longer be required to re-enter information in the medical record regarding the chief complaint and history that are already entered by ancillary staff or the beneficiary. Rather, the practitioner could indicate that they reviewed and verified the information.

Minimizing Documentation Requirements by Simplifying Payment Amounts

CMS believes that the current set of 10 CPT codes for new and established office-based and outpatient E/M visits and their respective payment rates no longer appropriately reflect the complete range of services and resource costs associated with furnishing E/M services to all patients across the different physician specialties and that documenting these services under the current guidelines has become burdensome and out of step with the current practice of medicine.

In conjunction with the proposal to reduce the documentation requirements for E/M visit levels 2 through 5, CMS is proposing to simplify the payment for those services by paying a single rate for the level 2 through 5 E/M visits. The agency considered creating new HCPCS G-codes that would describe the services associated with these proposed payment rates, however, due to the longstanding use of the existing codes by both Medicare and private payers, CMS believes it would have created unnecessary administrative burden to propose new coding.

For new patients, CMS is proposing a work RVU of 1.90, a physician time of 37.79 minutes and direct PE inputs that sum to \$24.98, based on an average of the current inputs for the individual codes weighted by 5 years of accumulated utilization data. Similarly, for existing patients, CMS is proposing a work RVU of 1.22 with a physician time of 31.31 minutes and direct PE inputs that sum to \$20.70. The below tables illustrate how these proposals would impact CY 2018 payments.

TABLE 19: Preliminary Comparison of Payment Rates for Office Visits New Patients

HCPCS Code	CY 2018 Non-facility Payment Rate	CY 2018 Non-facility Payment Rate under the proposed Methodology
99201	\$45	\$44
99202	\$76	\$135
99203	\$110	
99204	\$167	
99205	\$211	

TABLE 20: Preliminary Comparison of Payment Rates for Office Visits Established Patients

HCPCS Code	Current Non-facility Payment Rate	Proposed Non-facility Payment Rate
99211	\$22	\$24
99212	\$45	\$93
99213	\$74	
99214	\$109	
99215	\$148	

Recognizing the Resource Costs for Different Types of E/M Visits

CMS believes that the following three types of visits differ from the typical E/M service:

1. Separately identifiable E/M visits furnished in conjunction with a 0-day global procedure,
2. Primary care E/M visits for continuous patient care, and
3. Certain types of specialist E/M visits, including those with inherent visit complexity.

Additionally, CMS believes that when a separately identifiable visit is furnished in conjunction with a procedure, there are certain duplicative resource costs that are not accounted for by current coding and payment. Therefore, **CMS is proposing the following adjustments to better capture the variety of resource costs associated with different types of care provided in E/M visits:**

1. **An E/M multiple procedure payment adjustment to account for duplicative resource costs when E/M visits and procedures with global periods are furnished 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 levels 2 through level 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.**

Using the surgical MPPR as a template, **CMS is proposing that, as part of the proposal to make payment for the E/M levels 2 through 5 at a single MPFS rate, payment would be reduced 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 by an appended modifier -25.** To accurately reflect resource costs of the different types of E/M visits previously identified while maintaining work budget neutrality within this proposal, the agency proposes to allocate those RVUs toward the values of the add-on codes that reflect the additional resources associated with E/M visits for primary care and inherent visit complexity, similar to existing policies.

CMS is also proposing to create a HCPCS G-code for primary care services, 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)). This code would describe furnishing a visit to an established patient. HCPCS code GPC1X can 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.

The agency is proposing to create a new HCPCS code 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)). When billed in conjunction with standalone office/outpatient E/M visits for new and established patients, the combined valuation more accurately accounts for the intensity associated with higher level E/M visits. To establish a value for this add-on service to be applied with a standalone E/M visit, CMS is proposing a crosswalk to 75 percent of the work and time of CPT code 90785 (Interactive complexity), which results in a work RVU of 0.25, a PE RVU of 0.07, and an MP RVU of 0.01, as well as 8.25 minutes of physician time based on the CY 2018 valuation for CPT code 90785.

Recognizing the magnitude of the proposed coding and payment changes for E/M visits, CMS is proposing to create a single PE/HR value for E/M visits (including all of the proposed HCPCS G-codes discussed above) of approximately \$136, based on an average of the PE/HR across all specialties that bill these E/M codes, weighted by the volume of those specialties' allowed E/M services. If this proposal is finalized, CMS will consider reviewing the PE/HR after several years of claims data become available.

Finally, CMS is proposing to create a new HCPCS 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 (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)). This is in response to stakeholder feedback that the “first hour” time threshold in the descriptor for 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 (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)) is difficult to meet and is an impediment to billing these codes.

In estimating the impacts of the E/M coding and payment proposals, CMS estimates that the changes would result in minimal changes to overall payment for radiology, interventional radiology and nuclear medicine. The agency estimates a less than 3 percent decrease in overall payment for radiation oncology and radiation therapy centers.

GPCI Comment Solicitation (Page 380)

CMS is required to review and make adjustments, if necessary, to the GPCIs at least every 3 years. The last GPCI update was implemented in CY 2017 and as such, the next review will take place for CY 2020. **CMS is seeking comment on potential sources of commercial rent data for use in the next update.**

Physician Self-Referral Law (Page 487)

CMS is proposing revisions to regulations to address any actual or perceived difference between the statutory and regulatory language, to codify in regulation the longstanding policy regarding satisfaction of the writing requirement found in many of the exceptions to the physician self-referral law, and to make the Bipartisan Budget Act of 2018 policies applicable to compensation arrangement exceptions.

CMS is proposing to add a special rule on compensation arrangements providing that in the case of any requirement for a compensation arrangement to be in writing, the writing requirement may be satisfied by a collection of documents, including contemporaneous documents evidencing the course of conduct between the parties.

To conform the regulations with the recently added statutory provision CMS is proposing to amend existing §411.353(g) by: (1) revising the reference at §411.353(g)(1) to specific exceptions and signature requirements; (2) deleting the reference at §411.353(g)(1) to the occurrence of referrals or the payment of compensation during the 90-day period when the signature requirement is not met; and (3) deleting the limitation at §411.353(g)(2). In the alternative, CMS is proposing to delete §411.353(g) in its entirety and codify in proposed §411.354(e) the special rule for signature requirements in section 1877(h)(1)(E). The agency

seeks comments regarding the best approach for codifying in regulation this provision of the Bipartisan Budget Act of 2018.

CMS notes that the effective date of the Bipartisan Budget Act was February 9, 2018, and as such, parties who meet the requirements of section 1877(h)(1)(E) of the Act, including parties who otherwise would have been barred from relying on the special rule for certain arrangements involving temporary noncompliance with signature requirements because of the 3-year limitation may avail themselves of the new statutory provision.

Request for Information on Price Transparency (Page 917)

In the FY 2019 Inpatient Prospective Payment System (IPPS) proposed rule, CMS proposed to update guidelines to require hospitals to make available a list of their current standard charges via the Internet in a machine readable format and to update this information at least annually or more often as appropriate. The agency encourages all providers and suppliers to undertake efforts to engage in consumer-friendly communication of their charges to help patients understand what their potential financial liability might be for services they obtain and to enable patients to compare charges for similar services.

CMS is concerned about continued lack of price transparency for patients, including patients being surprised by out-of-network bills for physicians, such as anesthesiologists and radiologists who provide services at in-network hospitals and in other settings. CMS is considering ways to improve the accessibility and usability of current charge information. The agency is seeking public comment on the following:

- How should “standard charges” be defined in various provider and supplier settings?
- What types of information would be most beneficial to patients, how can providers and suppliers best enable patients to use charge and cost information in their decision-making and how can CMS and providers and suppliers help third parties create patient-friendly interfaces with these data?
- Should providers and suppliers be required to inform patients how much their out-of-pocket costs for a service will be before those patients are furnished that service? How can CMS help beneficiaries better understand how co-pays and co-insurance are applied to each service covered by Medicare?
- Can CMS require providers and suppliers to provide patients with information on what Medicare pays for a particular service performed by that provider or supplier?
- How does Medigap coverage affect patients’ understanding of their out-of-pocket costs before they receive care?

For questions on the Medicare Physician Fee Schedule proposed rule, please contact Katie Keysor at kkeysor@acr.org.