ACR Preliminary Summary of Radiology Payment Provisions in the 2019 Medicare Physician Fee Schedule Final Rule

The Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2019 Medicare Physician Fee Schedule (MPFS) final rule on Thursday, November 1st. Upon initial review, the ACR is pleased with several of the payment provisions within the rule. CMS finalized their proposal to use a series of G-codes and modifiers (to be specified in the 2020 rulemaking process) for claims processing in order to move forward with implementation of appropriate use criteria (AUC)/clinical decision support (CDS) for all advanced diagnostic imaging services on January 1, 2020. The ACR appreciates CMS' efforts to move forward with implementation of this important, Congressionally mandated utilization program.

Conversion Factor and CMS Overall Impact Estimates

CMS finalized a CY 2019 conversion factor of $36.0391, which reflects the 0.25 percent update specified by the Medicare Access and CHIP Reauthorization Act and a budget neutrality adjustment of -0.14 percent. Overall, this is a slight increase from the current conversion factor of $35.9996.

CMS estimates an overall impact of the MPFS changes to radiology to be a neutral, 0 percent change, while nuclear medicine and radiation oncology and radiation therapy centers will see an aggregate decrease of 1 percent and interventional radiology a 2 percent increase.

In the final rule, CMS made several refinements to their proposed valuation of new and revised codes based on feedback from stakeholders. While CMS maintained their proposed valuation for over 50% of the radiology-pertinent codes, the Agency did increase the valuation for the four breast MR codes as well as the contrast-enhanced ultrasound base code. Additionally, CMS is maintaining the current 2018 values for the 20 x-ray codes that were valued by the American Medical Association Relative Value Scale Update Committee (RUC) via a crosswalk methodology in lieu of the standard RUC survey. All of these codes were specifically addressed by the ACR and ASNR when we met with CMS on October 17th at the Baltimore headquarters.

Appropriate Use Criteria/Clinical Decision Support

After hearing concerns from various medical specialties societies on the readiness of the previously proposed July 1, 2019 implementation date, CMS finalized a January 1, 2020, implementation date in the 2018 final rule. This delay allows time to further develop claims processing instructions. Due to the complex nature of the AUC program, CMS finalized an "educational and operations testing period" of one year that will begin on January 1, 2020. During this period, ordering professionals will consult AUC and furnishing providers will report

AUC consultation information on the claim, but CMS will continue to pay claims whether or not the correct information is included. The agency notes that this educational period will allow professionals to actively participate in the program while avoiding claims denials during the learning curve.

In the 2019 final rule, CMS reaffirmed the January 1, 2020 mandatory consultation date, with a one-year education and operations testing period. To meet this deadline, CMS will develop a series of G-codes and modifiers for claims processing, to be described in detail in the 2020 rulemaking process. The agency notes that it will consider future opportunities to use a unique consultation identifier (UCI) for claims processing and will continue to engage with stakeholders on this topic.

In response to comments in the 2018 rulemaking cycle seeking clarification on who is required to perform the consultation of AUC through a qualified clinical decision support mechanism, CMS changed their proposal. In the proposed rule, CMS proposed that the consultation may be performed by "auxiliary personnel under the direction of, and incident to, the ordering physician or non-physician practitioner's professional service," which would allow flexibility, but still achieve the goal of the program to promote the use of AUC. The ACR requested in its comment letter that CMS revise the proposed language to require that "clinical personnel" perform the consultation and report back to the referring physician if the consultation results in a "not adhere response". CMS accepted the ACR's suggestion in the final rule and revised the language to indicate that "when delegated by the ordering professional, clinical staff under the direction of the ordering professional may perform the AUC consultation with a qualified clinical decision support mechanism."

CMS also finalized its proposal to add independent diagnostic testing facilities (IDTFs) to the definition of "applicable setting" for the AUC program. Other applicable settings include a physician's office, a hospital outpatient department (including an emergency department) and an ambulatory surgical center. The agency believes adding IDTFs as an applicable setting "appropriately and consistently applies the AUC program across the range of outpatient settings where applicable imaging services are furnished." The ACR supported this addition in its comment letter.

With regard to significant hardship exceptions, CMS finalized its proposal that an ordering professional experiencing any of the following when ordering an advanced diagnostic imaging service would not be required to consult AUC using a qualified CDSM:

- Insufficient internet access;
- EHR or CDSM vendor issues; or
- Extreme and uncontrollable circumstances (including natural or manmade disasters).

These circumstances will be self-attested and reported to the furnishing professional, who will then append an appropriate modifier indicating that the ordering professional reported a significant hardship exception.

In response to comments that those who participate in the Quality Payment Program (QPP) should be exempt from the AUC program, CMS indicated that there are "specific and distinct differences between the two programs" and it does not have the authority to expand the significant hardship exceptions to all those participating in the QPP.

Payment Rates for Nonexcepted Off-campus Provider-Based Hospital Departments Paid Under the MPFS

Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the Hospital Outpatient Prospective Payment System (OPPS) beginning January 1, 2017. For CY 2018, CMS pays for these items and services under the MPFS at a rate of 40 percent of the OPPS rate. For CY 2019, CMS finalized the proposal to maintain the current MPFS payment rates for these items and services at 40 percent of the OPPS payment rate.

Radiology Assistant Supervision

CMS finalized its proposal to revise the physician supervision requirements so that any diagnostic test performed by a Radiologist Assistant (RA) may be furnished under, at most, a direct level of physician supervision, when performed by an RA in accordance with state law and state scope of practice rules. This is in response to stakeholder comments that the current requirement of personal supervision that applies to some diagnostic tests is overly restrictive when the test is performed by an RA, and does not allow for radiologists to make full use of RAs; and that reducing the required level of supervision will improve efficiency of care.

Direct Practice Expense Inputs (DPEI)

CMS proposed to update pricing recommendations for 1,300 medical supplies and 750 medical equipment currently used as direct practice expense inputs. The agency proposed to phase-in use of the new direct practice expense input pricing over a 4-year period to lessen the potentially significant changes in payment that would occur. In the final rule, CMS cited that a delay in implementation would be unlikely to result in more accurate pricing information. Therefore, CMS finalized the 4-year pricing transition, beginning in CY 2019. CMS plans to work with stakeholders over the 4 years to identify individual supply and equipment codes that may require additional research into their pricing. However, for the ultrasound and vascular rooms, in response to comments received, CMS did not finalize the proposed room cost. Current prices for these rooms will be used in 2019. Additionally, CMS updated the pricing inputs for several radiation oncology equipment items.

Evaluation and Management (E/M) Services

CMS decided to move forward with proposed reduced documentation requirements for evaluation and management services. These provisions, which were supported by the ACR, AMA and many other specialty societies, were finalized for implementation in 2019.

In response to comments received from the AMA and many stakeholders, including the ACR, the agency chose to revise and delay its proposed single payment amount for office/outpatient E/M visit levels 2 through 5. Beginning in 2021, CMS will consolidate reimbursement for E/M visit levels 2 through 4, while maintaining a separate payment rate for more complex level 5 visits, as opposed to the proposal to create a single payment rate for levels 2 through 5. Additionally, CMS did not finalize the proposal to apply a multiple procedure payment reduction to E/M visits performed on the same day as procedures.

Additional Information

The MPFS also includes provisions for the Quality Payment Program, which are summarized in a separate document.

ACR staff will complete a detailed review of the entire final rule in the coming weeks. Additional information will be posted on the ACR website as it becomes available. CMS has posted a press release on their website. ACR staff will review the entire MPFS final rule in the coming weeks and will provide a comprehensive summary of the rule. The ACR will also submit comments to CMS by the comment period deadline on December 31st.

Please contact Katie Keysor at kkeysor@acr.org with any questions.