



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

The American College of Radiology (ACR) has prepared this detailed analysis of final changes to the payment provisions of the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2019. The ACR will provide comments by the December 31st comment period deadline. Changes finalized in this rule will be effective January 1, 2019.

Conversion Factor

CMS estimates 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. 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.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

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 proposed 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 finalized its proposal to revise the definition of applicable setting to include independent diagnostic testing facilities (IDTFs).**

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 proposed that the consultation may be performed by “auxiliary personnel incident to the ordering physician or non-physician practitioner’s professional service”.**

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 indicates that it is important to note that the 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.

The final rule indicates that while some commenters opposed the proposal, stating that the educational goals of the program would be undermined; however, the vast majority of commenters agreed that allowing the ordering professional flexibility provides the opportunity for the AUC consultation requirement to be less burdensome. CMS expects that when an AUC consultation is performed by someone other than the ordering professional and the result is that the imaging service does not adhere to the consulted AUC, that information will be provided back to the ordering professional to allow them to consider whether a different test (or no test) should be ordered, or if the original order is still appropriate for the patient.

In response to comments suggesting that furnishing professionals be allowed to consult AUC, CMS states, “While a furnishing professional may consult AUC as they wish for other purposes, such a consultation would not suffice for purposes of the AUC consultation required under this program. The AUC consultation must be performed by the ordering professional or an individual to whom the ordering professional has delegated it; and the ordering professional may only delegate the required AUC consultation to an individual as specified in our final policy.”

In response to comments received, CMS modified its proposal to state that, “when not personally performed by the ordering professional, the consultation with a qualified CDSM may be performed by clinical staff under the direction of the ordering professional.” The individual performing the AUC consultation must have sufficient clinical knowledge to interact with the CDSM and communicate with the ordering professional.

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 finalized its proposal 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 proposed 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.

CMS notes that the majority of commenters agreed with its proposed approach of using G-codes and modifiers to append AUC information on claims. **Some commenters suggested that CMS delay implementation until a UCI can be reported on claims. The agency responded by stating that it is important that it make strides to implement this program and prepare stakeholders for the method of reporting in the immediate years of the program. CMS will continue to explore the potential of using a UCI in the future.**

Some commenters suggested that CMS require the qualified CDSMs to report the applicable G-codes and modifiers to the ordering professionals in order to reduce the burden on providers of having to manually assign coding information to be transmitted for billing purposes. In response, CMS stated, **“As we move forward in finalizing our approach for claims-based reporting where CDSMs will be represented through G-codes, and AUC adherence represented through modifiers, we agree with commenters that CDSMs should include the G-codes and modifiers in their certification or documentation. We would like to see CDSMs begin to do**

this as the specific G-codes and modifiers become available. And as the commenters noted, this would seem to be a simple thing for CDSMs to do. If we do not see CDSMs making such adjustments to their certification or documentation, we will consider imposing a requirement in regulation.”

After reviewing public comments received, CMS finalized the proposal to use G-codes and modifiers to report consultation information on claims. Additional information will be provided in the coming months.

Significant Hardship Exception

CMS finalized the proposal to define 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 also finalized the proposal 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.

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.

CMS received several comments requesting that the hardship exceptions be significantly expanded to include clinicians in the Quality Payment Program (QPP), all primary care practitioners, hospitals and health systems and facility and institutional providers. Some of these commenters suggested that CMS should seek legislative authority to add such exceptions. CMS responded by citing the existing statutory language and stated that such blanket exceptions would not be consistent with the statutory requirements.

The agency notes that there are “specific and distinct differences” between the AUC program and the QPP. The AUC program was established to promote appropriate use of advanced diagnostic imaging and improve ordering patterns for these services through the consultation of AUC with real time reporting requirements and payment implications. While some components of the Quality Payment Program can involve using AUC and clinical decision support, their use is not mandatory, and the Quality Payment Program provides numerous options for participation across all MIPS performance categories. In contrast, consultation with AUC using a CDSM is required for each order for an applicable imaging service furnished in an applicable setting and paid under an applicable payment system under the AUC program. If amendments are made to the AUC statutory provisions, CMS will adjust its regulations throughout §414.94 accordingly. However, at this time, the agency does not have the authority to include exceptions to the AUC program beyond the scope of those specified in section 1834(q)(4)(C) of the Act.

In response to comments requesting that the furnishing provider be held harmless when ordering professionals self-attest to experiencing a significant hardship, CMS confirms that furnishing professionals and facilities are not held responsible for the self-attestation. The agency may monitor the use of these exceptions to ensure misuse or overuse does not become a problem. It is not appropriate for furnishing professionals or facilities to append significant hardship modifiers at their discretion and CMS notes that support for the use of such a modifier should be included by the ordering professional in the patient’s medical record.

Identification of Outliers

In the proposed rule, CMS invited 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 also indicated 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)

Low volume services

For CY 2019, CMS proposed to add 28 codes that were 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 proposed to assign expected specialty codes as listed in Table 1 in the rule. 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).

In our comment letter, the ACR made the following suggestions:

- CPT codes 70557 (Magnetic resonance (e.g., proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (e.g., to assess for residual tumor or residual vascular malformation); without contrast material) and 70558 (Magnetic resonance (e.g., proton) imaging, brain (including brain stem and skull base), during open intracranial procedure (e.g., to assess for residual tumor or residual vascular malformation); with contrast material(s)) are intraoperative exams and most often performed by neurosurgeons.
- 74235 (Removal of foreign body(s), esophageal, with use of balloon catheter, radiological supervision and interpretation) is a diagnostic radiology code rather than gastroenterology.
- 75810 (Splenoportography, radiological supervision and interpretation) should be assigned to interventional radiology rather than diagnostic radiology.
- 78282 (Gastrointestinal protein loss) and 79300 (Radiopharmaceutical therapy, by interstitial radioactive colloid administration) should be assigned to nuclear medicine rather than diagnostic radiology.

CMS agreed with these comments and made changes accordingly.

Changes to Direct PE Inputs for Specific Services

Standardization of Clinical Labor Tasks

In the proposed rule, CMS stated that “Prepare room, equipment and supplies” (CA013) has a standard of 3 minutes of clinical labor time. However, in the final rule, CMS clarifies that this statement was incorrect and that CA013, in fact, has a standard of 2 minutes, although they believe that that is not typical for many codes.

With the creation of the new PE spreadsheet, and as a result of translating old clinical labor activities to the new clinical labor codes, the minutes typically allotted to “Patient clinical information and questionnaire reviewed by technologist, order from physician confirmed and exam protocolled by radiologist” were divided into “Review patient clinical extant information and questionnaire” (CA007) and “Confirm order, protocol exam” (CA014).

Upon further review, CMS agreed that for codes which had the clinical labor task divided into CA007 and CA014, they would not be implementing the 3 minutes for CA013. For codes that only displayed time in CA014 and not in CA007, CMS will finalize the refinement to maintain 3 minutes for CA013 and remove the time from CA014.

Technical Corrections to Direct PE Input Database and Supporting Files

Based on comments received, CMS finalized the replacement of the 9 minutes of equipment time for the portable X-ray machine (EF041) with 9 minutes of equipment time for a basic radiology room (EL012) for CPT code 71045 (Radiologic examination, chest; single view).

The equipment cost per minute of the basic radiology room (48.4 cents) is nearly identical to the equipment cost per minute of the proposed Digital Radiography portable X-ray machine (46.0 cents), and CMS believes that it would better serve the interests of relativity for CPT code 71045 to match the same equipment inputs as the rest of the Chest X-Ray code family. CMS previously updated the PE RVU of this code in the July 2018 Quarterly Update (CMS Change Request 10644) based on the same information previously supplied by the commenters, and due to a technical error, this update to the direct PE inputs of CPT code 71045 was not included in the CY 2019 PFS proposed rule. CMS finalized this technical correction to the direct PE inputs of CPT code 71045 for CY 2019.

Updates to Prices for Existing Direct PE Inputs

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 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 Recommended Price (RP) methodology based on the following sources of current prices:

1. A proprietary database of buyer reported pricing,
2. Prices offered on General Services Administration (GSA) (note: this data was subsequently excluded from the recommended 2019 CMS prices),
3. Amazon Business,
4. Cardinal Healthcare, and
5. Vendors' and manufacturers' catalogs.

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 as the pricing updates recommended by StrategyGen are adopted. 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.

The ACR made general comments to CMS on the lack of transparency, issues with the data sources used by StrategyGen and the methodology used to determine final pricing inputs. **Despite comments received from the ACR and other stakeholders, CMS finalized its proposal to adopt the updates direct PE input prices for supplies and equipment as recommended by StrategyGen.**

Given the potentially significant changes in payment that will occur, both for specific services and more broadly at the specialty level, the agency finalized its proposal 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 specialty societies and other stakeholders to continue to evaluate the new pricing and submit invoices and other pricing data as needed. CMS reminds readers that to be included in a given year's proposed rule, information needs to be received by February 10th.

As a result of comments received, CMS included a list of approximately 60 supply and equipment items with updated pricing information. The list includes many radiation oncology supply and equipment items as well as the general and vascular ultrasound rooms. For the ultrasound items, CMS decided to maintain the current 2018 pricing pending additional research and analysis.

Breast Biopsy software (EQ370)

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 proposed not to update the price or add the software to these procedures.

In response to a comment requesting that CMS clarify the equipment items that make up the MR room (EL008), the final rule indicated that the MR room contains a 1.5T MR Scanner as well as coils, NV array, torso array, shoulder, wrist, extremity, dual array, power injector, and a computer workstation.

After consideration of the public comments, CMS finalized its proposal not to update the price of the Breast Biopsy software (EQ370). The agency noted that in light of information supplied by the ACR that the new CAD Software equipment (ED058) is actually synonymous with the Breast Biopsy software (EQ370), they had already proposed to include this equipment in CPT codes 77048 and 77049. CMS finalized the inclusion of the new CAD Software equipment (ED058) in these procedures, and finalized an update in the price of the CAD Software to \$43,308.12. This is based on a submitted invoice from commenters, which contained a price of \$52,725 as averaged together with additional invoices for the same CAD Software equipment researched by the StrategyGen contractor. CMS also finalized the replacement of the time assigned to the EQ370 Breast Biopsy software in CPT codes 19085, 19086, 19287, and 19288 with an equal amount of time assigned to the new ED058 CAD Software equipment. Finally, due to the continued confusion and lack of price for the EQ370 equipment item, and due to its redundancy with the new ED058 equipment code, CMS deleted EQ370.

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

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 proposed several concepts for increasing Medicare patients' access to physicians' services that are routinely furnished via communication technology.

Brief Communication Technology-Based Service

CMS finalized its proposal to pay separately for a newly defined type of physicians' service furnished using communication technology beginning January 1, 2019. This service, G2012 (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) will 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.

Remote Evaluation of Pre-Recorded Patient Information

CMS finalized its proposal to create, effective January 1, 2019 code G2010 (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 99452 (Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes) and 99451 (Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified 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 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. Therefore, CMS finalized its proposal to allow for separate payment for CPT codes 99451, 99452, 99446, 99447, 99448 and 99449.

Potentially Misvalued Services

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

In response to comments from the ACR and other stakeholders regarding the lack of transparency in indicated who nominated the codes as potentially misvalued, CMS provided a copy of the letter from Anthem and indicated that in the future, public nominations received by February 10th will be made available in the form of a public use file with the proposed rule.

The final rule states:

“Although we appreciate the comments that were received regarding the seven high volume codes, we believe that the nominator presented some concerns that have merit, such as the observation that in many cases time is reduced substantially but the work RVU only minimally, which results in an implied increase in the intensity of work that does not appear to be valid, and ultimately creates work intensity anomalies that are difficult to defend, and further review of these high-volume codes is the best way to determine the validity of the concerns articulated by the submitter. Therefore, we are adding CPT codes 27130, 27447, 43239, 45385, 70450, 93000, and 93306 to the list of potentially misvalued codes and anticipate reviewing recommendations from the RUC and other stakeholders.”

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 reported results from the first six months of data collection in the proposed rule. CMS sought comment on how to encourage reporting to ensure the validity of the data without imposing undue burden. The agency also asked 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 requested comment on whether they should consider changing the global period for the 10-day global codes and reviewing the code valuation.

The final rule noted that the Medicare Payment Advisory Commission (MedPAC) commented in support of converting all 10- and 90-day global codes to 0-day global codes and revaluing the codes as 0-day. Most other commenters were opposed to creating 0-day global services out of 10-day global services. Most suggested that improved reporting of post-operative visits is essential if the data is to be used to improve the accuracy of the existing codes.

CMS will evaluate the comments received and consider whether to propose action at a future date.

Radiologist Assistants

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 finalized its proposal 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 revised the regulations to add a new paragraph to state that diagnostic tests performed by a registered radiologist assistant (RRA) who is certified and registered by the American Registry of Radiologic Technologists or a radiology practitioner assistant (RPA) who is certified by the Certification Board for Radiology Practitioner Assistants, and that would otherwise require a personal level of supervision may be furnished under a direct level of physician supervision to the extent 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.

CMS will update guidance contained in Chapter 23 of the Medicare Claims Processing Manual to reflect the changes.

In response to comments that CMS clarify that all services within the RA scope of practice, including procedures, may be performed under direct supervision, the agency notes that supervision rules are only directly applicable to diagnostic tests, not procedures. CMS also notes that for procedures provided by auxiliary personnel (such as RAs) incident to the services of the billing physician or practitioner, Medicare generally requires direct supervision in accordance with regulations.

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

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 nonexcepted off-campus PBD under this policy. For CY 2018, the PFS Relativity Adjuster was changed to 40 percent.

For CY 2019, CMS finalized its proposal 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 finalized its proposal 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.

In response to comments received, CMS included the technical-equivalent rates that were developed specifically for calculating the PFS Relativity Adjuster for CY 2019, which is the current mechanism for implementing the PFS as the applicable payment system for nonexcepted items and services furnished in nonexcepted off-campus PBDs. This information is being made available under the downloads section for this final rule on the CMS website.

Valuation of Specific Codes

Fine Needle Aspiration (CPT codes 10021, 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, 10012, 76492, 77002 and 77021)

The CPT Editorial Panel was asked to bundle CPT codes 10021 and 10022 with imaging guidance, resulting in a total of ten new or revised codes to describe fine needle aspiration with and without imaging guidance. CPT code 10022 was deleted.

CMS received extensive comments regarding the valuation for these codes, including the use of CPT code 36440 as a crosswalk for CPT code 10021 and relying on incremental RVU increases instead of survey data. **However, following consideration of the comments, CMS ultimately decided to implement the values as initially proposed: 1.03 RVU for CPT code 10021, 0.80 RVUs for CPT code 10004, 1.46 RVUs for 10005, 1.00 RVUs for CPT code 10006, 1.81 RVUs for CPT code 10007, 1.18 RVUs for CPT code 10008, 2.26 RVUs for 10009, 1.65 RVUs for CPT code 10010, contractor pricing for CPT codes 10011 and 10012, 1.50 RVUs for CPT code 77021, 0.67 RVUs for CPT code 76942, and 0.54 RVUs for CPT code 77002.**

Knee Arthrography Injection (CPT code 27369)

CPT code 27369 was created to report injection procedure for knee arthrography or enhanced CT/MRI knee arthrography. This code replaces CPT code 27370, for which there were concerns about miscoding.

CMS was uncomfortable with the RUC-recommended 0.96 RVUs even though it was identical to the deleted code, 27370, stating that the surveyed physician times were lower than that of 27370. **Instead, CMS used reverse building block methodology to calculate a work RVU of 0.77 for CPT code 27369 based on the reduction in physician time.**

PICC Line Procedures (CPT codes 36568, 36569, 36572, 36573, and 36584)

The CPT Editorial panel revised CPT codes 36568, 36569, and 36584, and created two new codes, 36572 and 36573 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.

In the proposed rule, CMS refined the RUC-recommended values for some of the codes, citing rank order concerns with other codes in the family. However, commenters stated that they do not believe the codes to which CMS crosswalked the values were appropriate comparisons, and furthermore, that the codes involving imaging guidance should not be valued the same or less than the same code without imaging guidance. Commenters reiterated that, in addition to physician time, the patient population and intensity of the clinical work should also be considered when valuing codes.

CMS did not agree with the commenters and finalized 2.11 RVUs for CPT code 36568, 1.90 RVUs for 36569, 1.82 RVUs for 36572, 1.70 RVUs for 36573, and 1.20 RVUs for 36584.

Radioactive Tracer (CPT code 38792)

CMS finalized the RUC-recommended 0.65 RVUs for CPT code 38792, an increase over the current value of 0.52 RVUs.

Dilation of Urinary Tract (CPT codes 50436, 50437, 52334, and 74485)

Two new codes, 50436 and 50437, were created 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. Existing codes 52334 and 74485 were also valued as part of this family.

In the proposed rule, CMS did not agree with the identical RVU between CPT code 50436 and the deleted code, 50395, even though CPT code 50436 now bundles in imaging, citing the decrease in physician time. CMS was also uncomfortable with the RUC-recommended time for CPT code 50437 and proposed reducing it to the survey median time. CMS applied intraservice time ratios and used crosswalk codes to finalize the following values: 2.78 RVUs for CPT code 50436 and, after correcting a calculation error pointed out by a commenter, 4.85 RVUs for CPT code 50437.

CMS finalized the RUC-recommended 3.37 RVUs for CPT code 52334 and 0.83 RVUs for CPT code 74485.

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

In the proposed rule, CMS suggested applying the same work RVU to 20 X-ray procedures for which the RUC approved a “crosswalk methodology” for valuation. In addition to the twelve X-ray of the spine codes, the other procedures included X-ray of the toe, heel, sacrum, sacroiliac joints, elbow, and forearm. CMS indicated that without survey data, they did not have any information with which to help them determine whether the RUC-recommended (crosswalked) values were appropriate, citing potential improvements in efficiency or changes in practice patterns, time and intensity. Instead, CMS applied a utilization-weighted average to all of the codes, resulting in 0.23 RVUs for each of the 20 codes.

Many commenters did not agree with CMS’s proposal to value all 20 X-ray codes identically, stressing the differences in the number of views and the complexity of positioning patients for some procedures.

Upon reviewing the comments, CMS stated that they would be maintaining the 2018 work RVUs for each of the codes. The values for the twelve X-ray spine codes are as follows: 0.15 RVUs for CPT code 72020, 0.22 RVUs for CPT code 72040, 0.31 RVUs for CPT code

72050, 0.36 RVUs for CPT code 72052, 0.22 RVUs for CPT code 72070, 0.22 RVUs for CPT code 72072, 0.22 RVUs for CPT code 72074, 0.22 RVUs for CPT code 72080, 0.22 RVUs for CPT code 72100, 0.31 RVUs for CPT code 72110, 0.32 RVUs for CPT code 72114, and 0.22 RVUs for CPT code 72120.

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

In the proposed rule, CMS suggested applying the same work RVU to 20 X-ray procedures for which the RUC approved a “crosswalk methodology” for valuation. In addition to the three X-ray of the sacrum codes, the other procedures included X-ray of the toe, heel, spine, elbow, and forearm. CMS indicated that without survey data, they did not have any information with which to help them determine whether the RUC-recommended (crosswalked) values were appropriate, citing potential improvements in efficiency or changes in practice patterns, time and intensity. Instead, CMS applied a utilization-weighted average to all of the codes, resulting in 0.23 RVUs for each of the 20 codes.

Many commenters did not agree with CMS’s proposal to value all 20 X-ray codes identically, stressing the differences in the number of views and the complexity of positioning patients for some procedures.

Upon reviewing the comments, CMS stated that they would be maintaining the 2018 work RVUs for each of the codes. The values for the three X-ray sacrum codes are as follows: 0.17 RVUs for CPT code 72200, 0.19 RVUs for CPT code 72202, and 0.17 RVUs for CPT code 72220.

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

In the proposed rule, CMS suggested applying the same work RVU to 20 X-ray procedures for which the RUC approved a “crosswalk methodology” for valuation. In addition to the three X-ray of the elbow or forearm codes, the other procedures included X-ray of the toe, heel, spine, sacrum, and sacroiliac joints. CMS indicated that without survey data, they did not have any information with which to help them determine whether the RUC-recommended (crosswalked) values were appropriate, citing potential improvements in efficiency or changes in practice patterns, time and intensity. Instead, CMS applied a utilization-weighted average to all of the codes, resulting in 0.23 RVUs for each of the 20 codes.

Many commenters did not agree with CMS’s proposal to value all 20 X-ray codes identically, stressing the differences in the number of views and the complexity of positioning patients for some procedures.

Upon reviewing the comments, CMS stated that they would be maintaining the 2018 work RVUs for each of the codes. The values for the three X-ray elbow or forearm codes are as follows: 0.15 RVUs for CPT code 73070, 0.17 RVUs for CPT code 73080, and 0.16 RVUs for CPT code 73090.

X-Ray Heel (CPT code 73650)

In the proposed rule, CMS suggested applying the same work RVU to 20 X-ray procedures for which the RUC approved a “crosswalk methodology” for valuation. In addition to the X-ray of the heel code, the other procedures included X-ray of the toe, spine, elbow, forearm, sacrum, and sacroiliac joints. CMS indicated that without survey data, they did not have any information with which to help them determine whether the RUC-recommended (crosswalked) values were appropriate, citing potential improvements in efficiency or changes in practice patterns, time and intensity. Instead, CMS applied a utilization-weighted average to all of the codes, resulting in 0.23 RVUs for each of the 20 codes.

Many commenters did not agree with CMS’s proposal to value all 20 X-ray codes identically, stressing the differences in the number of views and the complexity of positioning patients for some procedures.

Upon reviewing the comments, CMS stated that they would be maintaining the 2018 work RVUs for each of the codes. The value for the X-ray heel code is 0.16 RVUs for CPT code 73650.

X-Ray Toe (CPT code 73660)

In the proposed rule, CMS suggested applying the same work RVU to 20 X-ray procedures for which the RUC approved a “crosswalk methodology” for valuation. In addition to the X-ray of the toe code, the other procedures included X-ray of the heel, spine, elbow, forearm, sacrum, and sacroiliac joints. CMS indicated that without survey data, they did not have any information with which to help them determine whether the RUC-recommended (crosswalked) values were appropriate, citing potential improvements in efficiency or changes in practice patterns, time and intensity. Instead, CMS applied a utilization-weighted average to all of the codes, resulting in 0.23 RVUs for each of the 20 codes.

Many commenters did not agree with CMS’s proposal to value all 20 X-ray codes identically, stressing the differences in the number of views and the complexity of positioning patients for some procedures.

Upon reviewing the comments, CMS stated that they would be maintaining the 2018 work RVUs for each of the codes. The value for the X-ray toe code is 0.13 RVUs for CPT code 73660.

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

CMS accepted the RUC-recommendations for the three x-ray esophagus codes: 0.59 RVUs for CPT code 74210, 0.67 RVUs for CPT code 74220, and 0.53 RVUs for CPT code 74230.

Per CMS request, commenters provided detailed information about the use typical use of Polibar barium suspension in these procedures, explaining that it is appropriate to include in both CPT codes 74220 and 74210, and in the quantities approved by the RUC.

X-Ray Urinary Tract (CPT code 74420)

CMS accepted the RUC-recommendation of 0.52 RVUs for CPT code 74420.

Fluoroscopy (CPT code 76000)

CMS finalized the RUC-recommendation of 0.30 RVUs for CPT code 76000.

Ultrasound Elastography (CPT codes 76981, 76982, and 76983)

CMS finalized the RUC-recommendations for the three new ultrasound elastography codes used to assess organ parenchyma and focal lesions: 0.59 RVUs for CPT code 76981, 0.59 RVUs for CPT code 76982, and 0.50 RVUs for add-on CPT code 76983.

Ultrasound Exam - Scrotum (CPT code 76870)

CMS finalized the RUC-recommendation of 0.64 RVUs for CPT code 76870.

Contrast-Enhanced Ultrasound (CPT codes 76978 and 76979)

CPT created two new codes to describe the use of intravenous microbubble agents to evaluate lesions by ultrasound.

In the proposed rule, CMS expressed their concern for the RUC-recommendation of 1.62 RVU for CPT code 76978 since it was based on a crosswalk instead of survey data, and proposed a refined value of 1.27 RVUs. However, based on commenter feedback, specifically the fact that CEUS requires higher technical skill and more time than other established ultrasound services, CMS reconsidered their proposed value.

CMS finalized 1.62 RVUs for CPT code 76978 and 0.85 RVUs for CPT code 76979.

Magnetic Resonance Elastography (CPT code 76391)

A new CPT code, 76391, was created to describe the use of magnetic resonance elastography to evaluate organ parenchymal pathology.

CMS was not comfortable with the RUC-recommended 1.29 RVUs for CPT code 76391, expressing concerns about its relativity to other imaging codes with similar intraservice times. Instead, CMS proposed 1.10 RVUs based on the intraservice-time ratio and comparisons to other reference codes.

CMS finalized the refined value of 1.10 RVUs for CPT code 76391.

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

CMS finalized the RUC-recommendation of 1.50 RVUs for CPT code 77012.

CMS received several comments in response to their proposal to decrease the RUC-approved CT room time to the nine minutes typically assigned to the room for radiological and supervision procedures. Commenters referred to language from 2013 and stated that the precedent of nine minutes applies only to angiographic rooms. However, CMS did not agree and will apply nine minutes of time for the CT room for CPT code 77012.

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

CMS finalized the RUC-recommendation of 0.20 RVUs for CPT code 77081.

Breast MRI with Computer-Aided Detection (CPT codes 77046, 77047, 77048, and 77049)

Four new codes were created to describe breast MRI with and without contrast (including CAD), 77046, 77047, 77048, and 77049.

In the proposed rule, CMS refined the value for 77046 from 1.45 RVUs to 1.15 RVUs based on differences in the physician time between the new code and CPT code 77058, which it is replacing. CMS then applied the RUC-approved incremental differences between 77046 and the other three codes in order to value them.

Commenters disagreed with CMS's rationale and argued that the value for 77058 should not be used as a point of reference for reducing the value of 77046, since the structure of the breast MRI family has fundamentally changed, along with the work involved in each of the new codes. Commenters also did not agree with the reference code, 77334, which CMS used as a crosswalk to value CPT code 77046. Upon review of the comments, CMS agreed that their proposed value of 1.15 RVUs would create a rank order anomaly among the MRI codes.

CMS finalized the RUC-recommended values for breast MRI, as follows: 1.45 RVUs for CPT code 77046, 1.60 RVUs for CPT code 77047, 2.10 RVUs for CPT code 77048, and 2.30 RVUs for CPT code 77049.

CMS expressed their appreciation for the submission of invoices to assist in the pricing of five new equipment items. Upon reviewing these invoices, **CMS finalized the pricing of the following three items: \$83,200 for the breast coil (EQ388), \$43,308.12 for the CAD software (ED058), and \$12,031.52 for the CAD workstation (ED056). CMS does not consider the other two equipment items, the CAD server (ED057) and additional CAD software license (ED059) to be direct expenses under the PE methodology.**

Evaluation and Management (E/M) Visits

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 proposed several changes to E/M visit documentation and payment. The agency received thousands of comments on these proposals. The majority of commenters expressed appreciation for the efforts to reduce physician burden, but expressed concern about the impacts of the proposals.

Eliminating Extra Documentation Requirements for Home Visits

CMS finalized its proposal 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.

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 received many comments in response to the request 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. **The agency will review the comments received and consider this issue further for potential future rulemaking.**

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

After considering public comments, CMS did not finalize its proposal 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 for 2019. Therefore, for 2019 and 2020, practitioners should continue to use either the 1995 or 1997

versions of the E/M guidelines to document E/M office/outpatient visits. Beginning in 2021, for E/M office/outpatient levels 2 through 5 visits, the agency will allow for flexibility in how visit levels are documented, specifically a choice to use the current framework, medical decision making (MDM) or time. Also beginning in 2021, CMS will apply a minimum supporting documentation standard associated with level 2 visits when practitioners use the current framework or MDM to document the visit.

In response to comments received, the agency did not finalize its proposal of a single payment amount for office/outpatient E/M visit levels 2 through 5 beginning January 1, 2019. Instead, beginning in 2021, CMS will pay a single rate for E/M office/outpatient visit levels 2, 3 and 4 (one rate for new patients and a separate rate for established patients). E/M level 5 visits will not be included in the single payment rate in order to account for the care and needs of particularly complex patients.

CMS will continue to engage in dialog with the public over the next several years to potentially further refine these policies for 2021.

Removing Redundancy in E/M Visit Documentation

CMS finalized its proposal 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, effective January 1, 2019. Additionally, the for both new and established patients, practitioners will 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 response to comments received, CMS did not finalize its proposal to simplify the payment for E/M services by paying a single rate for the level 2 through 5 E/M visits beginning January 1, 2019. Instead, beginning in 2021, CMS will apply a single payment rate for levels 2 through 4 E/M office/outpatient visits and will maintain separate payment rates for new and established patients for level 5 E/M office/outpatient visits to account for the most complex patients and visits. The payment rates for levels 2 through 4 visits will be valued using the weighted average of the current inputs (work RVUs, direct PE inputs, time and specialty mix) assigned to the individual codes, based on the most recent 5 years of utilization for each of the constituent codes. For the level 1 and level 5 office/outpatient E/M visits, CMS will finalize payment rates that rely on current inputs. The inputs used (in the absence of

intervening changes to CPT coding or the development of other considerations) to develop proposed values for these services for 2021 appear in the Table 21.

TABLE 21: Finalized Inputs for E/M Office/Outpatient Codes for 2021

HCPCS	Physician Time	Work RVU	Malpractice RVU	Sum of Direct PE Inputs
99201	17.00	0.48	0.05	\$13.97
99202	34.43	1.76	0.17	\$24.37
99203	34.43	1.76	0.17	\$24.37
99204	34.43	1.76	0.17	\$24.37
99205	67.00	3.17	0.28	\$30.92
99211	7.00	0.18	0.01	\$11.31
99212	30.26	1.18	0.08	\$20.41
99213	30.26	1.18	0.08	\$20.41
99214	30.26	1.18	0.08	\$20.41
99215	55.00	2.11	0.14	\$27.83

CMS also finalized separate, add-on payments for visit complexity inherently associated with primary care and non-procedural specialty care, as well as separate payment for extended visits via HCPCS G-codes.

CMS is aware that the American Medical Association (AMA) and the CPT Editorial Panel have convened a work group to revisit E/M coding in response to the proposals. The agency notes that the 2-year delay in implementation will provide the opportunity to respond to the work done by the group, as well as other stakeholders.

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

CMS proposed 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.

In response to comments received, CMS did finalize its proposal to reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in

the same group practice) furnishes on the same day as a separately identifiable E/M visit, currently identified on the claim by an appended modifier -25.

CMS intends to consider ways to address the practice of scheduling patients to avoid payment adjustments in future rulemaking. In addition, CMS will continue to explore comments related the valuation of codes with global periods that are perceived to include no resource costs associated with evaluation and management and the agency intends to reconsider appropriate global periods assigned to certain services. CMS welcomes stakeholder input on this topic.

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

CMS proposed 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 could also be reported for other forms of face-to-face care management, counseling, or treatment of acute or chronic conditions not accounted for by other coding.

The American Academy of Family Physicians did not support the add-on code in its comments to CMS. Rather, they suggested that CMS provide a 15 percent increase in payment to physicians who list their primary practice designation as family medicine, internal medicine, pediatrics or geriatrics. Many other specialty stakeholders commented in support of the proposal, but indicated concern that the code not be limited to certain specialty designations.

After consideration of the comments, CMS finalized for 2021 the proposal to introduce add-on codes that would adjust payment for new and established E/M office/outpatient visits to account for inherent complexity in primary care and non-procedural specialty care. The agency notes that when clinical circumstances support it, practitioners not enrolled among the specialties expressly listed within the code descriptor pay bill the inherent visit complexity add-on codes.

CMS did not finalize its proposal to create a single PE/HR value for E/M visits (including all of the proposed HCPCS G-codes) 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.

CMS finalized for 2021, its proposal to create a new HCPCS code GPRO1 (Extended time for evaluation and management service(s) in the office or other outpatient setting, when the visit requires direct patient contact of 34-69 total face-to-face minutes overall for an existing patient or 38-39 minutes for a new patient (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service)).

In estimating the impacts of the E/M coding and payment proposals for 2021, CMS estimates that the changes would result a 2 percent overall payment reduction for radiology and

interventional radiology, a 3 percent payment reduction for nuclear medicine and an overall 1 percent reduction in payment for radiation oncology and radiation therapy centers. These reductions are likely due to budget neutrality RVU adjustments.

Physician Self-Referral Law

CMS proposed 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 finalized its proposal 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 finalized its proposal 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).

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.

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