CY 2019 Medicare PFS Final Rule
A Comprehensive Review from ACG, AGA and ASGE

REVISIONS TO PHYSICIAN FEE SCHEDULE PAYMENT POLICIES

Conversion Factor: With the statutorily mandated budget neutrality adjustment to account for changes in RVUs, the final 2019 PFS conversion factor is $36.04, a slight increase above the 2018 PFS conversion factor of $35.99.

Misvalued Code Initiative: As previously reported, the health insurer Anthem nominated two GI codes as potentially "misvalued." CMS, in this final rule, agreed to Anthem's petition to include 45385 (*Colonoscopy with lesion removal by snare*) and 43239 (*EGD biopsy single/multiple*) for review under the potentially misvalued code initiative. The GI societies oppose CMS' decision to place these services on the misvalued code list.

ACG, AGA and ASGE in a meeting with CMS and in our joint comments to CMS argued against the assertion that 45385 and 43239 are misvalued and should face review. While reimbursement changes to physician work for GI services are not expected before the CY 2021 payment year, it may be necessary to conduct surveys via the American Medical Association's (AMA) Relative-value Scale Update Committee (RUC) in 2019. **If so, we need your input on the time, complexity, and physician work value for these procedures.** If you receive a survey, please complete it. We cannot win this fight without you.

Reforming Evaluation and Management (E/M) Payment: CMS finalized changes to streamline E/M documentation for 2019, but the Agency is not implementing two proposals opposed by the GI societies: (1) application of a multiple-procedure payment reduction to separate E/M services furnished on the same day as a global procedure and (2) standardization of the allocation of practice expense RVUs for the E/M services. Both of these proposals would have negatively affected gastroenterology payments.

CMS will continue the current coding and payment structure for E/M office and outpatient visits for CY 2019 and CY 2020. Practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare. Additional modifications to E/M documentation for CY 2019 include the following:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit.
- Elimination of the need to re-enter the defined list of required elements for established patients when relevant information is already in the medical record as long as the previous information is reviewed and updated as needed. This allows practitioners to focus documentation on what has changed since the last visit.

- Elimination of the need to re-enter information on the patient's chief complaint and history that has already been entered by ancillary staff or the patient.
- Removal of the potentially duplicative requirements for notations in medical records that may have previously been included by residents or other members of the medical team for E/M visits furnished by teaching physicians.

Beginning in 2021, CMS plans to implement a new payment structure for E/M services that collapses Levels 2-4 into a single payment rate. CMS has generated a brief summary describing the proposed changes to E/M structure and payment. This new payment structure will apply to both new and established patients. The collapsing of the E/M codes and a single payment will have a redistributive effect on the specialties that bill E/M codes. The GI societies will continue to monitor and engage with stakeholders to mitigate the potential impact on gastroenterology practices.

Practice Expense - Market-Based Supply and Equipment Pricing Update: Practice expense (PE) is the portion of the resources used in furnishing a service that reflects the general categories of physician and practitioner expenses, such as office rent and personnel wages, but excluding malpractice (MP) expenses. CMS worked with a contractor to conduct a market research study to update the PFS direct PE inputs for supply and equipment pricing for CY 2019. These supply and equipment prices were last systematically developed in 2004-2005. CMS is finalizing the proposal to adopt updated direct PE input prices for supplies and equipment and they will phase-in use of these new prices over a 4-year period beginning in CY 2019.

A report from the contractor with updated pricing recommendations for approximately 1300 supplies and 750 equipment items currently used as direct PE inputs is available here.

Brief Communication Technology-based Service, e.g. Virtual Check-in: CMS has finalized its proposal to make separate payment for brief communication technology-based services. The code will be described as G2012 (*Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report E/M 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*). If the service originates from a related E/M service provided within the previous seven days by the same physician or other qualified health care professional, this service would be considered bundled into that previous E/M service and would not be separately billable. In instances when the service leads to an E/M service with the same physician or other qualified health care professional, this service would be considered bundled into the pre- or post-visit time of the associated E/M service, and therefore, would not be separately billable.

This finalized proposal allows for billing of real-time, audio-only telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. The National MPFS payment rate for CY2019 will be $14.78.

Remote Evaluation of Pre-Recorded Patient Information: CMS finalized its proposal to make separate payment for remote evaluation of pre-recorded patient information. The code will be described as G2010 (*Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with 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*). When the review of the patient-submitted image or video results in an in-person E/M office visit with the same physician or qualified health care professional, this remote service will be considered bundled into that office visit and, therefore, will not be separately billable. In instances when the remote service originates from a related E/M service

provided within the previous seven days by the same physician or qualified health care professional, this service will be considered bundled into that previous E/M service, and, therefore, would not be separately billable. The National MPFS payment rate for CY2019 will be $12.61.

This finalized proposal establishes policies to pay separately for new coding describing chronic care remote physiologic monitoring (CPT codes 99453, 99454, and 99457) and interprofessional internet consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449).

Payment Rates for Non-excepted Off-campus Provider-Based Hospital Departments Paid Under the OPPS: In CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services. The PFS Relativity Adjuster in CY 2018 is 40 percent, meaning that non-excepted items and services are paid 40 percent of the amount that would have been paid for those services under the OPPS. CMS has finalized that the PFS Relativity Adjuster remain at 40 percent for CY 2019. The Agency has stated its belief that the PFS Relatively Adjuster encourages fairer competition between hospitals and physician practices by promoting greater payment alignment between outpatient care settings.

QUALITY PAYMENT PROGRAM'S MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS)

Summary of MIPS Performance Categories

Clinician payment adjustments under MIPS are based on scores that clinicians receive in 4 different performance categories, which are weighted as follows:

Performance Category	*CY 2018 Weight**	*CY 2019 Weight (Proposed)**	*CY 2019 Weight (Final)**
Cost (Resource Use)	**10%**	**15%**	***15%***
Quality	**50%**	**45%**	***45%***
Improvement Activities	**15%**	**15%**	***15%***
Promoting Interoperability (formerly Advancing Care Information)	**25%**	**25%**	***25%***

* Weights are reassigned if MIPS eligible clinicians are exempted from a particular performance category.

Performance Threshold: CMS finalized a performance threshold of 30 points for the 2021 payment year, which doubles the required points from Year 2 to Year 3. Eligible clinicians must achieve at least 30 points to avoid a negative payment adjustment of up to -7%. CMS stated that it did not believe it was unreasonable to double the performance threshold and would encourage clinicians to gain experience with all MIPS performance categories. CMS also set the "exceptional performance" threshold at 75 points. Beginning with the 2024 payment year, CMS will calculate the performance threshold using the mean or median of final performance scores.

Quality Performance Category and Gastroenterology Specialty Measure Set: CMS is finalizing its proposal to weight the quality performance category at 45 percent for the 2021 MIPS payment year.

The requirements for the Quality Performance Category of MIPS remain largely unchanged for the 2019. The performance period will be the entire 2019 calendar year. The same data completeness requirements as Year 2 of MIPS depending upon collection type for patients seen during the performance period to which a measure applies remain in place.

CMS created and maintains, with input from the GI societies, a gastroenterology measure set for use in MIPS. Gastroenterologists are not required to report on the measure set nor report on every measure in a set. A MIPS eligible clinician (or group) is only required to submit data on six measures. If a MIPS eligible clinician reports on less than six quality measures, s/he will be subjected to the eligible measure applicability process that will validate whether the clinician actually had less than six measures available or applicable to their scope of practice. Furthermore, MIPS eligible clinicians must report at least one outcome measure. If an applicable outcome measure is not available, they must report one other high priority measure. The gastroenterology measure set includes outcome and high priority measures. One notable difference for 2019 is that measure #185: Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use can no longer be reported using Part B claims. This measure remains available for registry-based reporting.

Beginning with the 2019 performance period, CMS is allowing MIPS eligible clinicians and groups to submit data collected via multiple collection types within a performance category. Further details on data submission to the Quality performance category can be found in the Quality Payment Program Year 3 overview fact sheet.

Cost Category: CMS is finalizing its proposal to weight the cost performance category at 15 percent for the 2021 MIPS payment year. There are no submission requirements for cost measures, which are collected from claims data.

For the 2021 payment year, CMS has added eight episode-based cost measures that will let clinicians who are attributed those measures know the cost of the care clinically related to their initial treatment of a patient and provided during the episode's timeframe. Among the eight is the "screening and surveillance colonoscopy" episode-based cost measure. The GI societies were significantly involved in the development of the measure and in providing feedback to CMS during the measure's testing period. CMS defines "cost" based on the allowed amounts on Medicare claims, which include both Medicare payments and beneficiary deductible and coinsurance amounts. Episode-based measures are calculated using Medicare Parts A and B fee-for-service claims data and are based on episode groups.

Improvement Activities Category: CMS is finalizing its proposal to weight the improvement activities performance category at 15 percent for the 2021 MIPS payment year.

The performance period for improvement activities will continue as a 90-day continuous period during the calendar year. MIPS eligible clinicians must submit a yes attestation for activities within the improvement activities inventory.

Promoting Interoperability Category *(previously known as the Advancing Care Information)***:** CMS is finalizing its proposal to weight the promoting interoperability performance category at 25 percent for the 2021 MIPS payment year.

Beginning with the 2019 performance period, MIPS eligible clinicians must use electronic health record (EHR) technology certified to the 2015 Edition certification criteria.

For the 2019 performance period, CMS finalized a new scoring methodology for the Promoting Interoperability category which is designed to reduce burden for clinicians and enable them to focus more on patient care. MIPS eligible clinicians will need to report on all of the required measures across all objectives to earn any score at all for the Promoting Interoperability performance category. Failure to report a required measure or reporting a "no" response on a "yes or no" response measure, unless an exclusion applies, will result in a score of zero. Further details on the scoring of the Promoting Interoperability performance category can be found in the Quality Payment Program Year 3 overview fact sheet.

Low-Volume Threshold and MIPS Opt-in Policy: Beginning with the 2021 MIPS payment year and beyond, eligible clinicians or groups meet the low-volume threshold if they meet *at least one* of the following three criteria during the MIPS determination period: (1) those who have allowed charges for covered professional services less than or equal to $90,000; (2) those who provide covered professional services to 200 or fewer Part B- enrolled individuals; or (3) those who provide 200 or fewer covered professional services to Part B-enrolled individuals. MIPS eligible clinicians or groups who do not exceed the low-volume threshold are except from participating in MIPS.

For the first time beginning with the 2021 MIPS payment year, if an individual eligible clinician or group exceeds at least one, but not all, of the low-volume threshold criteria, the individual clinician or group can opt to participate in MIPS by reporting on applicable measures and activities and receive a payment adjustment.

Small Practice Bonus: CMS increased the small practice bonus for the 2021 payment year. A small practice bonus of 6 measure bonus points will be added to the numerator of the quality performance category for MIPS eligible clinicians in small practices if the MIPS eligible clinician submits data to the Quality performance category on at least one measure. CMS had proposed a bonus of 3 points. The current bonus is 5 points and is added to the overall performance score.

Facility-Based Measurement: CMS finalized its proposal to implement facility-based measurement for the 2019 MIPS performance period. A MIPS eligible clinician who furnishes 75 percent or more of his or her covered professional services in the hospital inpatient, hospital outpatient or emergency room (identify by place of service codes 21, 22 and 23) is eligible as an individual for facility-based measurement.

CMS defines a facility-based group as one in which 75 percent or more of the eligible clinician NPIs billing under the group's TIN are eligible for facility-based measurement as individuals.

CMS will automatically apply facility-based measurement to eligible individuals and groups; there is no opt-in or opt-out. Individuals and groups who submit quality measures using other submission types would be assigned the higher of the two scores.

There are no submission requirements for individual clinicians in facility-based measurement, but a group must submit data in the Improvement Activities or Promoting Interoperability performance categories to be measured as a group under facility-based measurement.

The GI societies are preparing a response to the key issues and will submit it to CMS prior to the deadline of 5 pm Eastern Time on December 31, 2018.