CMS Proposed Physician Fee Schedule Rule 2019

Key Medicare Fee Schedule Proposals:

- With the budget neutrality adjustment to account for relative value changes, as required by law, the proposed 2019 PFS conversion factor is $36.05, a slight increase above the 2018 PFS conversion factor of $35.99.
- CMS has proposed to collapse payment for office and outpatient visits. New patient office visit (99202-99205) payments would be blended to be $135. Established office visits (99212-99215) would be blended to be paid at $93. New codes would be created to provide add-on payments to office visits for specific specialties ($9) and primary care physicians ($5).
- To replace existing documentation guidelines, CMS proposes to allow use of (1) 1995 or 1997 documentation guidelines; (2) medical decision-making or (3) time. Documentation for history and exam will focus on interval history since last visit. Physicians will be allowed to review and verify certain information in the medical record entered by ancillary staff or the beneficiary, rather than re-entering the information.
- When physicians report an E/M service and a procedure on the same date, CMS proposes to implement a 50% multiple procedure reduction to the lower paid of the two services.
- CMS will implement new CPT codes and payment for remote monitoring and interprofessional consultations.
- CMS updated supplies and equipment pricing. The re-pricing of antigens has a significant impact on allergy and immunology payments, with an estimated 6% reduction for the specialty.

Highlights of the Merit-based Incentive Payment System (MIPS) proposals:

- Retain the low-volume threshold but add a third criteria of providing fewer than 200 covered professional services to Part B patients.
- Retaining bonus points for:
    - Care of complex patients
    - End-to-end reporting
    - Small practices
- Allowing eligible clinicians to opt-in if they meet one or two, but not all, of the low volume threshold criterion.
- Consolidating the low-volume threshold determination periods with the determination period for identifying a small practice.
- Eliminate the base and performance categories and reduced the number of measures in the Promoting Interoperability category.
- Require Eligible clinicians to move to 2015 CEHRT.
- Providing the option to use facility-based scoring for facility-based clinicians.
- For 2019 performance year the weights are:
    - Quality - 45%
    - Cost- 15%
    - Promoting Interoperability – 25%
    - Improvement Activities- 15%

As a reminder, as a result of AMA advocacy, the Bipartisan Budget Act of 2018 provided additional flexibility for CMS on several MIPS issues including:

- Excluding Medicare Part B drug costs from MIPS payment adjustments and from the low-volume threshold determination;
- Allowing CMS to reweight the cost performance category to not less than 10 percent and not more than 30 percent for 2019-2021 performance years; and
- Allowing CMS flexibility in setting the performance threshold for performance years 2019-2021to provide a gradual and incremental transition for physicians.

CMS has provided Fact Sheets on the major components of the rule which are available at the following links:
https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12-2.html
https://www.cms.gov/Medicare/Quality-Payment-Program/Resource-Library/2019-QPP-proposed-rule-fact-sheet.pdf . In addition, the specialty impact table from the rule is attached for your information.