



Calendar Year (CY) 2019 Medicare Physician Fee Schedule (PFS) Final Rule

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- Final Rule Provisions- General
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- Final Policies for E/M Visits Starting in 2019
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- Advancing Virtual Care
- Quality Payment Program: Merit-based Incentive Payment System (MIPS) Year 3 (2019) Final
- Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging
- Medicare Shared Savings Program ACOs
- Combatting Opioid Use Disorder
- Medicare Diabetes Prevention Program

Final Rule Provisions- General



- Final 2019 PFS conversion factor is \$36.04
- Phase-in use of new practice expense prices for supplies & equipment over a 4-year period
- Flexibility for Radiology Assistants
- New modifiers for Physical Therapy Assistants and Occupational Therapy Assistants
- Ambulance fee schedule temporary add-on payments extended through 2022 (Bipartisan Budget Act of 2018)
- Reduction of add-on percentage for certain wholesale acquisition cost (WAC)-based payments for new Part B drugs

Final Rule Provisions- Medicare Telehealth Services



- Adding HCPCS codes G0513 and G0514 (Prolonged preventive service(s))
- Implementing requirements of the Bipartisan Budget Act of 2018:
 - Adding renal dialysis facilities and homes of ESRD beneficiaries receiving home dialysis as originating sites
 - Removing originating site geographic requirements for hospital-based or CAH-based renal dialysis centers, renal dialysis facilities, and beneficiary homes
 - Adding mobile stroke units as originating sites
 - Not applying originating site type and geographic requirements for telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke

Final Policies for E/M Visits Starting in 2019



For 2019 and beyond, CMS finalized the following optional but broadly supported documentation changes for E/M visits, that do not require changes in coding/payment.

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For history and exam for established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.

Final Policies for E/M Visits Starting in 2019

(cont.)



- Additionally, we are clarifying that for chief complaint and history for new and established patient office/outpatient visits, practitioners need not re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

Policies for E/M Office/Outpatient Visits Starting in 2021



- Beginning in CY 2021, CMS will implement payment, coding, and additional documentation changes for E/M office/outpatient visits, specifically:
 - Single rates for levels 2 through 4 for established and new patients, maintaining the payment rates for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;
 - Add-on codes for level 2 through 4 visits that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care

Policies for E/M Office/Outpatient Visits Starting in 2021 (cont.)



- A new “extended visit” add-on code for level 2 through 4 visits to account for the additional resources required when practitioners need to spend additional time with patients.
- For level 2 through 5 visits, choice to document using the current framework, MDM or time;
 - When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary (typical CPT time for code reported, plus any extended/prolonged time).
 - When using current framework or MDM to document, for level 2 through 4 visits CMS will only require the supporting documentation currently associated with level 2 visits.

E&M Payment Amounts



		Current (2018) Payment Amount	Revised Payment Amount***				
	Complexity Level under CPT	Visit Code Alone*	Visit Code Alone Payment	Visit Code With Either Primary or specialized care add-on code**	Visit Code with New Extended Services Code (Minutes Required to Bill)	Visit with Both Add-on and Extended Services Code Added**	Current Prolonged Code Added (Minutes Required to Bill)*
New Patient	Level 2	\$76	\$130	\$143	\$197 (at 38 minutes)	\$210	
	Level 3	\$110					
	Level 4	\$167					
	Level 5	\$211	\$211		\$344 (at 90 minutes)		
Established Patient	Level 2	\$45	\$90	\$103	\$157 (at 34 minutes)	\$170	
	Level 3	\$74					
	Level 4	\$109					
	Level 5	\$148	\$148		\$281 (at 70 minutes)		

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately \$133.

Physician groups have routinely complained to CMS that billing prolonged with any regularity tends to prompt medical review and is ultimately cost-prohibitive.

**In cases where one could bill both the primary and specialized care add-on, there would be an additional \$13.

***The dollar amounts included in this projection are based on 2019 payment rates; actual amounts in 2021 when the policy takes effect will differ.



To support access to care using communication technology, we are finalizing policies to:

- Pay clinicians for virtual check-ins – brief, non-face-to-face assessments via communication technology (HCPCS code G2012).
- Pay clinicians for remote evaluation of patient-submitted photos or recorded video (HCPCS code G2010).
- Pay Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for these kinds of services - outside of the RHC all-inclusive rate and the FQHC Prospective Payment System rate.
- CMS is also finalizing 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).

Quality Payment Program: Merit-based Incentive Payment System (MIPS) Year 3 (2019) Final



MIPS Eligible Clinician Types:

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Register Nurse Anesthetists
- Groups of such clinicians



Year 3 (2019) Final

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)

AND:

- Clinical Psychologists
- Physical Therapists
- Occupational Therapists
- Speech-Language Pathologists
- Audiologists
- Registered Dieticians or Nutrition Professionals



Low-Volume Threshold Determinations:

- Added a third element – Number of Services – to the low-volume threshold determination criteria
- The finalized criteria include:
 - Dollar amount - \$90,000 in covered professional services under the Physician Fee Schedule (PFS)
 - Number of beneficiaries – 200 Medicare Part B beneficiaries
 - Number of services (*New*) – 200 covered professional services under the PFS
- Added an opt-in option for Year 3:
 - If you are a MIPS eligible clinician and meet or exceed at least one, but not all, of the low-volume threshold criteria, you may opt-in to MIPS
 - If you opt-in, you'll be subject to the MIPS performance requirements, MIPS payment adjustment, etc.

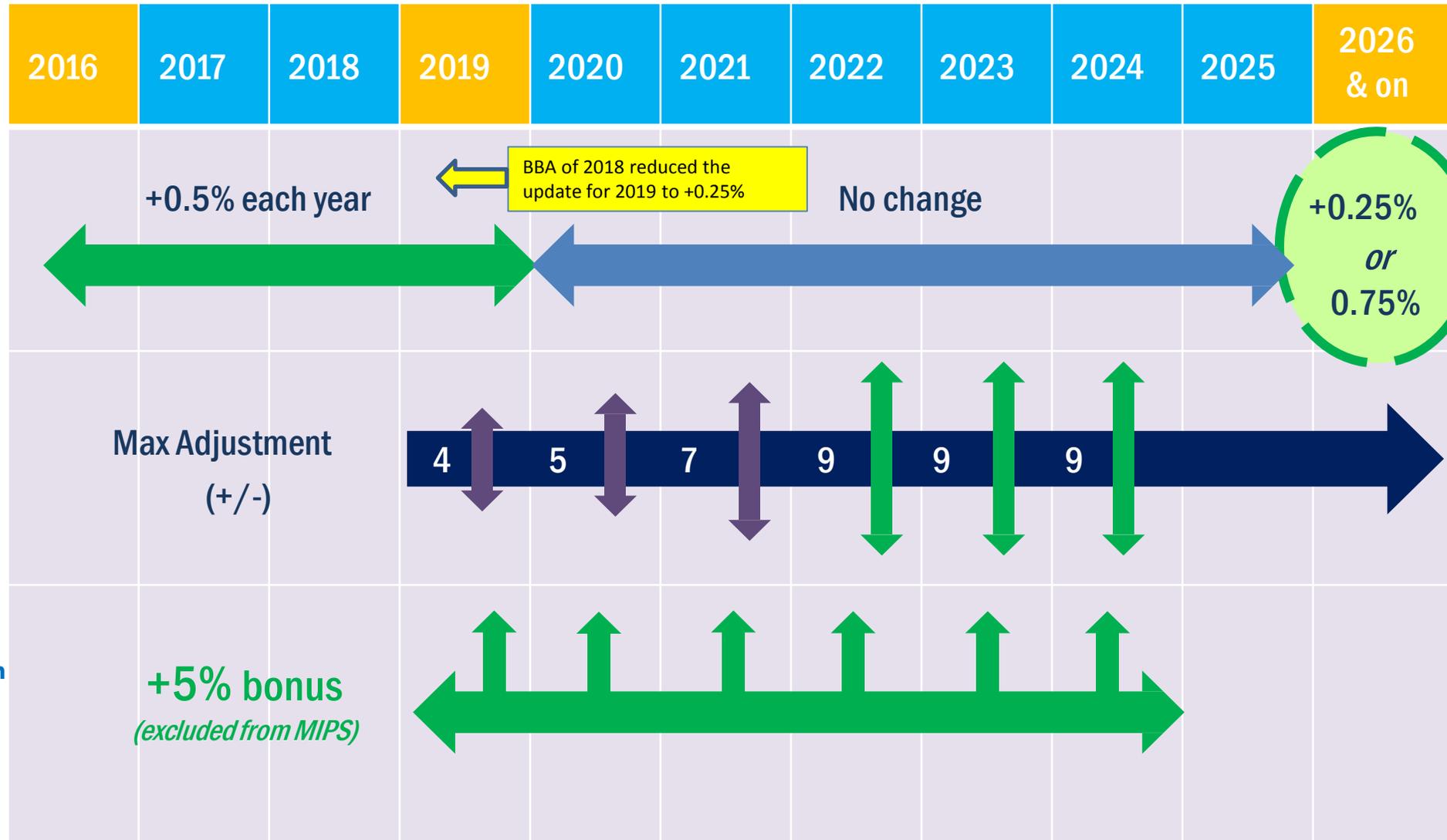
MIPS Opt-In Scenarios



Dollars	Beneficiaries	Professional Services (<i>New</i>)	Eligible for Opt-in?
≤ 90K	≤ 200	≤ 200	No – excluded
≤ 90K	≤ 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	≤ 200	Yes (may also voluntarily report or not participate)
> 90K	≤ 200	>200	Yes (may also voluntarily report or not participate)
≤ 90K	> 200	> 200	Yes (may also voluntarily report or not participate)
> 90K	> 200	> 200	No – required to participate

- MIPS eligible clinicians who meet or exceed at least one, but not all, of the low-volume threshold criteria may choose to participate in MIPS

Medicare Reimbursement/Adjustments



QPP: MIPS Year 3 (2019) Final



Performance Category Weights:

Performance Category	Performance Category Weights		
	Year 1 (2017)	Year 2 (2018)	Year 3 (2019) – Final
 Quality	60%	50%	45%
 Cost	0%	10%	15%
 Improvement Activities	15%	15%	15%
 Promoting Interoperability	25%	25%	25%



Performance Categories – Additional High-Level Changes:

- **Quality:** Removed certain measures as a part of the Meaningful Measures Initiative and shifted the small practice bonus (worth 6 points) from the final score calculation into this performance category
- **Cost:** Added 8 new episode measures
- **Facility-based quality and cost measures:** Clinicians who are hospital-based can use their hospital's performance under the Hospital Value-Based Purchasing (VBP) Program for the MIPS quality and cost performance categories
- **Improvement Activities:** Refinements made to the Improvement Activities inventory
- **Promoting Interoperability:** Overhauled the category to simplify, focus on interoperability, align clinician policies with hospital policies, reduce measures, and change scoring to be focused on performance

QPP: MIPS Year 3 (2019) Final



Performance Threshold and Payment Adjustment:

Performance Period	Performance Threshold	Exceptional Performance Bonus	Payment Adjustment*
Year 1 (2017)	3 points	70 points	Up to +4%
Year 2 (2018)	15 points	70 points	Up to +5%
Year 3 (2019) - Final	30 points	75 points	Up to +7%

*Payment adjustment (and exceptional performer bonus) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance. To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a “scaling factor.” The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging



- CMS is finalizing the revision of the significant hardship criteria in the AUC program to include:
 - 1) Insufficient internet access;
 - 2) Electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues;
 - 3) Extreme and uncontrollable circumstances.
- CMS is also finalizing allowing ordering professionals experiencing a significant hardship to self-attest their hardship status.
- CMS is adding independent diagnostic testing facilities (IDTFs) to the definition of applicable setting under this program. This will allow the AUC program to be more consistently applied to outpatient settings.
- CMS is also allowing AUC consultations, when not personally performed by the ordering professional, to be performed by clinical staff under the direction of ordering professional. This will allow the ordering professional to exercise their discretion to delegate the performance of this consultation

Medicare Shared Savings Program (Shared Savings Program) Accountable Care Organizations (ACOs)



In order to ensure continuity of participation, CMS is finalizing the following policies:

- A voluntary 6-month extension for existing ACOs whose participation agreements expire on December 31, 2018, and the methodology for determining financial and quality performance for this 6-month performance year from January 1, 2019, through June 30, 2019.
- Allowing beneficiaries who voluntarily align to a Nurse Practitioner, Physician Assistant, Certified Nurse Specialist, or a physician with a specialty not used in assignment to be prospectively assigned to an ACO if the clinician they align with is participating in an ACO, as provided for in the Bipartisan Budget Act of 2018.
- Revising the definition of primary care services used in beneficiary assignment.
- Providing relief for ACOs and their clinicians impacted by extreme and uncontrollable circumstances in 2018 and subsequent years.
- Reducing the Shared Savings Program core quality measure set by eight measures; and promoting interoperability among ACO providers and suppliers by adding a new CEHRT threshold criterion to determine ACOs' eligibility for program participation and retiring the current Shared Savings Program quality measure on the percentage of eligible clinicians using CEHRT.

Final Rule Provisions- Combatting Opioid Use Disorder



- Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act:
 - Interim rule with comment period: removing originating site geographic requirements and adds home of an individual as permissible originating site for telehealth services (substance use disorder or co-occurring mental health disorder, after 7/1/2019)
 - New benefit category for opioid use disorder treatment services furnished by opioid treatment programs (OTPs) under Medicare Part B on or after 1/1/2020
- Opioid-related provisions in Quality Payment Program
 - Quality performance category: definition of “high priority” measures now includes opioid-related measures
 - Two new opioid-related measures for the e-Prescribing objective in the Promoting Interoperability performance category

Comment Solicitation on Creating a Bundled Episode of Care for Management and Counseling Treatment for Substance Use Disorders



- In the CY 2019 PFS proposed rule, CMS sought comment on creating a bundled episode of care for management and counseling treatment for substance use disorders.
- Comment was also sought for regulatory and sub-regulatory changes to help prevent opioid use disorder and improve access to treatment under the Medicare program.
- CMS sought comment on methods for identifying non-opioid alternatives for pain treatment and management, along with identifying barriers that may inhibit access to these non-opioid alternatives including barriers related to payment or coverage. CMS received many comments on these solicitations with detailed information to help inform future rulemaking.

New Medicare Part D Prescription Opioid Policies for 2019



- CMS finalized new policies for Medicare drug plans to follow starting on January 1, 2019.
- These policies involve further partnership with providers and prescription drug plans.
- Providers are in the best position to identify and manage potential opioid overutilization in the Medicare Part D population.
- CMS tailored its approach to help distinct populations of Medicare Part D opioid users:
 - New opioid users (opioid naïve),
 - Chronic opioid users,
 - Users with potentially problematic concurrent medication use, and
 - High risk opioid users.

Opioid Policy Summary



- Improved **safety edits** when opioid prescriptions are dispensed at the pharmacy
- **Drug management programs** for patients determined to be at-risk for misuse or abuse of opioids or other frequently abused drugs
- Opioid Naïve Seven-day Supply Limit
- Care Coordination Alert
- Drug Management Programs
- Case Management Process
- Drug Management Program Tools

Medicare Diabetes Prevention Program

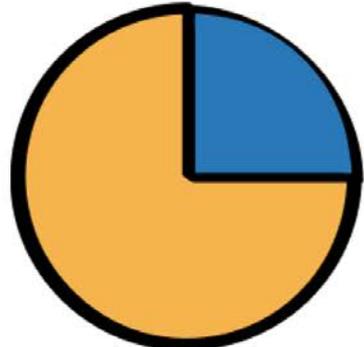


The Problem:

25%

Americans 65 and older with type 2 diabetes

Care for these individuals costs Medicare about **\$104^B** each year, and is growing

A pie chart is integrated into the number '0' of the '\$104B' figure. The pie chart is divided into four quadrants, with the top-right quadrant shaded in blue, representing 25% of the total.

Medicare Diabetes Prevention Program



Pre-Diabetes:

- **Serious & Common**
- More than **84 million US adults**—that’s 1 in 3—have [pre-diabetes](#).
- With pre-diabetes, blood sugar is higher than normal but not high enough yet to be diagnosed as diabetes. **People with pre-diabetes are at high risk for [type 2 diabetes](#) (the most common type of diabetes), heart disease, and stroke.**
- In the last 20 years, the number of adults diagnosed with diabetes **has more than tripled as the US population has aged and become more overweight.**
- Now more than **30 million Americans have diabetes**, which increases their risk for a long list of serious health problems, including:
 - Heart attack
 - Stroke
 - Blindness
 - Kidney failure
 - Loss of toes, feet, or legs

Medicare Diabetes Prevention Program



The Solution:

Medicare pays organizations, called MDPP suppliers, to furnish a group-based intervention to at-risk Medicare beneficiaries, using a CDC-approved National Diabetes Prevention Program curriculum.



Up to 2 years of sessions delivered to groups of eligible beneficiaries

As a Medicare preventive service, there are no out-of-pocket costs



DIET



PHYSICAL
ACTIVITY



WEIGHT LOSS

Coaches furnish MDPP services on behalf of MDPP suppliers

MDPP suppliers' primary goal is to help Medicare beneficiaries achieve at least 5% weight loss

Medicare Diabetes Prevention Program



What Is Covered through the Model?:

The first year of MDPP core services includes six months of weekly core sessions followed by six months of monthly maintenance sessions; the second year is contingent upon beneficiary's achieving attendance and weight loss goals and consists of monthly maintenance sessions.



- Follows a CDC-approved curriculum
 - No beneficiary copay
 - No referral required

* The ongoing maintenance sessions are unique to the MDPP services and not required for CDC recognition.

Medicare Diabetes Prevention Program



Better Outcomes, Higher Incentives:

Payments are made based on beneficiary attendance *and* beneficiary weight loss.

<i>Year 1 Payment Scenarios*</i>		
Attendance	Weight Loss (WL)	Total Payment Made
1 Core Session	N/A	\$25
9 Core Sessions	Without 5% WL	\$165
9 Core Sessions	With 5% WL	\$325
Full (9 Core, 4 Core Maintenance)	No WL	\$195
Full (9 Core, 4 Core Maintenance)	5% WL (mos. 0 – 6) & maintains WL in mos. 7-12	\$445

**Note: in Year 2, suppliers can also receive up to 4 payments of \$50 (total potential of \$200) per beneficiary, assuming ongoing maintenance session attendance and maintenance of 5% weight loss; the maximum payment per beneficiary is \$670 over 2 years*

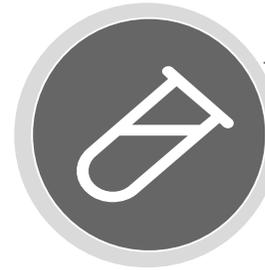
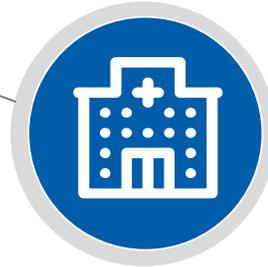
Medicare Diabetes Prevention Program



Who Is Eligible?:

Medicare Eligibility

Beneficiaries must have coverage through Original Medicare (Part B) or Medicare Advantage (Part C)



Blood Tests and Body Mass Index (BMI)

Beneficiaries must present one of three blood tests indicating prediabetes and have their BMI measured



Other Medical History

Beneficiaries must not have a previous diagnosis of diabetes or End Stage Renal Disease, and no previous receipt of MDPP services

Medicare Diabetes Prevention Program



Becoming an MDPP Supplier:

Organizations must meet key requirements and complete an application to become MDPP suppliers.

1. Gain CDC Recognition



- Organizations must have **either CDC full or preliminary recognition**
- Visit the [CDC website](#) to learn more about gaining recognition

2. Enroll as an MDPP supplier

- Enroll using the online [PECOS application](#) or the [CMS-20134 form](#)

3. Furnish MDPP Services

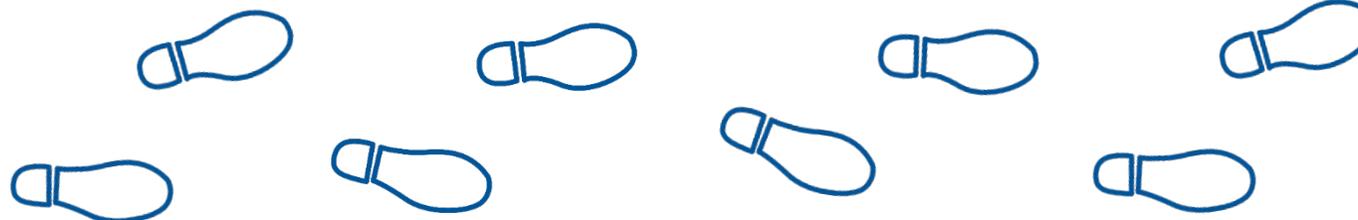
- MDPP services must be **furnished to eligible MDPP beneficiaries** by an enrolled MDPP supplier



4. Submit Claims to Medicare



- Suppliers will submit claims to their **Medicare Administrative Contractor (MAC)**, or when applicable, submit encounter data to a **Medicare Advantage organization**



Medicare Diabetes Prevention Program



More Resources:



Ready to become a CDC-recognized National DPP delivery organization?

Head to the [National DPP Website](#) and visit the new [National DPP Customer Service Center](#)

Ready to enroll as an MDPP supplier?

Once recognized by CDC (either full or preliminary status), enroll online through the Provider Enrollment Chain and Ownership System (PECOS) [here](#). Review the enrollment application [here](#)



Want to access supplier support resources?

Head to the [MDPP Website](#)



Want to access a map of existing MDPP suppliers?

Head to the [MDPP Supplier Map](#)



Want to find out which organizations are eligible to become MDPP suppliers?

Head to [CDC's National DPP Registry](#), and look for “Full” or “Preliminary” recognition organizations



Other ways to stay updated or ask questions

Sign up for our listserv at [MDPP Website](#) or email us at mdpp@cms.hhs.gov

For Further Information



See the Physician Fee Schedule website at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>

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