



Summary of Policies in the Calendar Year (CY) 2019 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

MLN Matters Number: MM11063 **Revised**

Related Change Request (CR) Number: 11063

Related CR Release Date: November 30, 2018

Effective Date: January 1, 2019

Related CR Transmittal Number: R4176CP

Implementation Date: January 7, 2019

Note: We revised this article on March 4, 2019, to inform providers that, as established through CY 2019 PFS rulemaking, effective for dates of service on or after January 1, 2019, Medicare no longer requires the functional reporting nonpayable HCPCS G-codes and severity modifiers – adopted to implement section 3005(g) of the Middle Class Tax Relief and Job Creation Act (MCTRJCA) of 2012 – on claims for therapy services. For details about these payment policies, see MLN Matters article MM11120 at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11120.pdf>.

PROVIDER TYPES AFFECTED

This MLN Matters Article is intended for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services paid under the Medicare Physician Fee Schedule (MPFS) and provided to Medicare beneficiaries.

PROVIDER ACTION NEEDED

CR 11063 provides a summary of policies in the Calendar Year (CY) 2019 MPFS Final Rule and announces the Telehealth Originating Site Facility Fee payment amount and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2019. Make sure your billing staffs are aware of these updates.

BACKGROUND

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year.

The Centers for Medicare & Medicaid Services (CMS) final rule (Regulation number CMS-1693-F) that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2019 went on display on November 1, 2018. The final rule also addresses public comments on Medicare payment policies proposed earlier this year. The following summarizes the key provisions of this final rule.

Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden

For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare. For CY 2019 and beyond, CMS is finalizing the following policies:

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit
- 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. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.
- CMS is clarifying that for E/M office/outpatient visits, for new and established patients for visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history 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.
- Removal of potentially duplicative requirements for notations in medical records that may have previously been included in the medical records by residents or other members of the medical team for E/M visits furnished by teaching physicians.

Beginning in CY 2021, CMS will further reduce burden with the implementation of payment, coding, and other documentation changes. Payment for E/M office/outpatient visits will be simplified and payment would vary primarily based on attributes that do not require separate, complex documentation. Specifically for CY 2021, CMS is finalizing the following policies:

- Reduction in the payment variation for E/M office/outpatient visit levels by paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients
- Permitting practitioners to choose to document E/M office/outpatient level 2 through 5 visits using Medical Decision Making (MDM) or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework

- Beginning in CY 2021, for E/M office/outpatient levels 2 through 5 visits, CMS will allow for flexibility in how visit levels are documented— specifically a choice to use the current framework, MDM, or time. For E/M office/outpatient level 2 through 4 visits, when using MDM or current framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or MDM.
- 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.
- Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements.
- Adoption of a new “extended visit” add-on code for use only with E/M office/outpatient level 2 through 4 visits to account for the additional resources required when practitioners need to spend extended time with the patient.

CMS believes these policies will allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary. CMS intends to engage in further discussions with the public to potentially further refine the policies for CY 2021.

After consideration of concerns raised by commenters in response to the proposed rule, CMS is not finalizing aspects of the proposal that would have:

1. Reduced payment when E/M office/outpatient visits are furnished on the same day as procedures
2. Established separate coding and payment for podiatric E/M visits
3. Standardized the allocation of practice expense Relative Value Unit (RVUs) for the codes that describe these services

Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

CMS is finalizing its proposals to pay separately for two newly defined physicians’ services furnished using communication technology:

- Brief communication technology-based service, for example, virtual check-in (Healthcare Common Procedure Coding System (HCPCS) code G2012)
- Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010)

CMS is also finalizing policies to pay separately for new coding describing chronic care remote physiologic monitoring (Current Procedural Terminology (CPT) codes 99453, 99454, and

99457) and interprofessional internet consultation (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449).

Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder and Other Substance Use Disorders

Through an interim final rule with comment period, CMS is implementing a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act that removes the originating site geographic requirements and adds the home of an individual as a permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder for services furnished on or after July 1, 2019.

Providing Practice Flexibility for Radiologist Assistants

CMS is revising the physician supervision requirements so that diagnostic tests performed by a Radiologist Assistant (RA) that meets certain requirements, that would otherwise require a personal level of physician supervision as specified in its regulations, may be furnished under a direct level of physician supervision to the extent permitted by state law and state scope of practice regulations.

Discontinue Functional Status Reporting Requirements for Outpatient Therapy

CMS is finalizing its proposal to discontinue the functional status reporting requirements for services furnished on or after January 1, 2019.

Outpatient Physical Therapy and Occupational Therapy Services Furnished by Therapy Assistants

The Bipartisan Budget Act of 2018 requires payment for services furnished in whole or in part by a therapy assistant at 85 percent of the applicable Part B payment amount for the service effective January 1, 2022. In order to implement this payment reduction, the law requires CMS to establish a new modifier by January 1, 2019, and CMS to detail its plans to accomplish this in the final rule.

CMS is finalizing its proposal to establish two new modifiers – one for Physical Therapy Assistants (PTA) and another for Occupational Therapy Assistants (OTA) – when services are furnished in whole or in part by a PTA or OTA. However, CMS is finalizing the new modifiers as “payment” rather than as “therapy” modifiers, based on comments from stakeholders. These will be used alongside of the current PT and OT modifiers, instead of replacing them, which retains the use of the three existing therapy modifiers to report all PT, OT, and Speech Language Pathology (SLP) services, that have been used since 1998 to track outpatient therapy services that were subject to the therapy caps.

CMS is also finalizing a de minimis standard under which a service is furnished in whole or in part by a PTA or OTA when more than 10 percent of the service is furnished by the PTA or

OTA, instead of the proposed definition that applied when a PTA or OTA furnished any minute of a therapeutic service. The new therapy modifiers for services furnished by PTAs and OTAs are not required on claims until January 1, 2020.

Practice Expense (PE): Market-Based Supply and Equipment Pricing Update

CMS is finalizing the proposal to adopt updated direct PE input prices for supplies and equipment. While CMS is adopting most of the prices for supplies and equipment as recommended by the contractor and included in the proposed rule, in the case of particular items, CMS is finalizing refinements to the proposed prices based on feedback from commenters. CMS is also finalizing its proposal to phase-in use of these new prices over a 4-year period beginning in CY 2019 to ensure a smooth transition.

Payment Rates for Non-excepted Off-campus Provider-Based Hospital Departments Paid Under the PFS

Section 603 of the Bipartisan Budget Act of 2015 requires that certain items and services furnished by certain off-campus hospital outpatient provider-based departments are no longer paid under the Hospital Outpatient Prospective Payment System (OPPS) and are instead paid under the applicable payment system. In CY 2017, CMS finalized the PFS as the applicable payment system for most of these items and services.

Since CY 2017, payment for these items and services furnished in non-excepted off-campus provider-based departments has been made under the PFS using a PFS Relativity Adjuster based on a percentage of the OPPS payment rate. 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 is finalizing that the PFS Relativity Adjuster remain at 40 percent for CY 2019. CMS believes that this PFS Relativity Adjuster encourages fairer competition between hospitals and physician practices by promoting greater payment alignment between outpatient care settings.

Medicare Telehealth Services

For CY 2019, CMS is finalizing its proposals to add HCPCS codes G0513 and G0514 (Prolonged preventive service(s)) to the list of telehealth services.

CMS is also finalizing policies to implement the requirements of the Bipartisan Budget Act of 2018 for telehealth services related to beneficiaries with End-Stage Renal Disease (ESRD) receiving home dialysis and beneficiaries with acute stroke effective January 1, 2019. CMS is finalizing the addition of renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis as originating sites, and to not apply originating site geographic requirements for hospital-based or critical access hospital-based renal dialysis centers, renal dialysis facilities, and beneficiary homes, for purposes of furnishing the home dialysis monthly ESRD-related clinical assessments.

CMS is also finalizing policies to add mobile stroke units as originating sites and not to apply

originating site type or geographic requirements for telehealth services furnished for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.

Telehealth origination site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act. The MEI increase for 2019 is 1.5 percent. Therefore, for CY 2019, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or \$26.15. (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance.)

ADDITIONAL INFORMATION

The official instruction, CR 11063, issued to your MAC regarding this change is available at <https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R4176CP.pdf>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
March 4, 2019	We revised this article to inform providers that, effective for services on or after January 1, 2018, Section 50202 of the Bipartisan Budget Act (BBA) of 2018 repeals application of the Medicare outpatient therapy caps but retains the former cap amounts as a threshold of incurred expenses above which claims must include a KX modifier as confirmation that services are medically necessary as justified by appropriate documentation in the medical record; and retains the targeted medical review process, but at a lower threshold amount. In addition, effective for dates of service on or after January 1, 2019, as established through CY 2019 PFS rulemaking, Medicare no longer requires the functional reporting nonpayable HCPCS G-codes and severity modifiers – adopted to implement section 3005(g) of MCTRJCA of 2012 – on claims for therapy services. For details, see MLN Matters article MM11120 at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM11120.pdf .

Date of Change	Description
December 3, 2018	Initial article released.

Disclaimer: This article was prepared as a service to the public and is not intended to grant rights or impose obligations. This article may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents. CPT only copyright 2017 American Medical Association. All rights reserved.

Copyright © 2018, the American Hospital Association, Chicago, Illinois. Reproduced with permission. No portion of the AHA copyrighted materials contained within this publication may be copied without the express written consent of the AHA. AHA copyrighted materials including the UB-04 codes and descriptions may not be removed, copied, or utilized within any software, product, service, solution or derivative work without the written consent of the AHA. If an entity wishes to utilize any AHA materials, please contact the AHA at 312-893-6816. Making copies or utilizing the content of the UB-04 Manual, including the codes and/or descriptions, for internal purposes, resale and/or to be used in any product or publication; creating any modified or derivative work of the UB-04 Manual and/or codes and descriptions; and/or making any commercial use of UB-04 Manual or any portion thereof, including the codes and/or descriptions, is only authorized with an express license from the American Hospital Association. To license the electronic data file of UB-04 Data Specifications, contact Tim Carlson at (312) 893-6816 or Laryssa Marshall at (312) 893-6814. You may also contact us at ub04@healthforum.com

The American Hospital Association (the "AHA") has not reviewed, and is not responsible for, the completeness or accuracy of any information contained in this material, nor was the AHA or any of its affiliates, involved in the preparation of this material, or the analysis of information provided in the material. The views and/or positions presented in the material do not necessarily represent the views of the AHA. CMS and its products and services are not endorsed by the AHA or any of its affiliates.