

# Physician Fee Schedule 2019 Proposed Rule

August 15, 2018

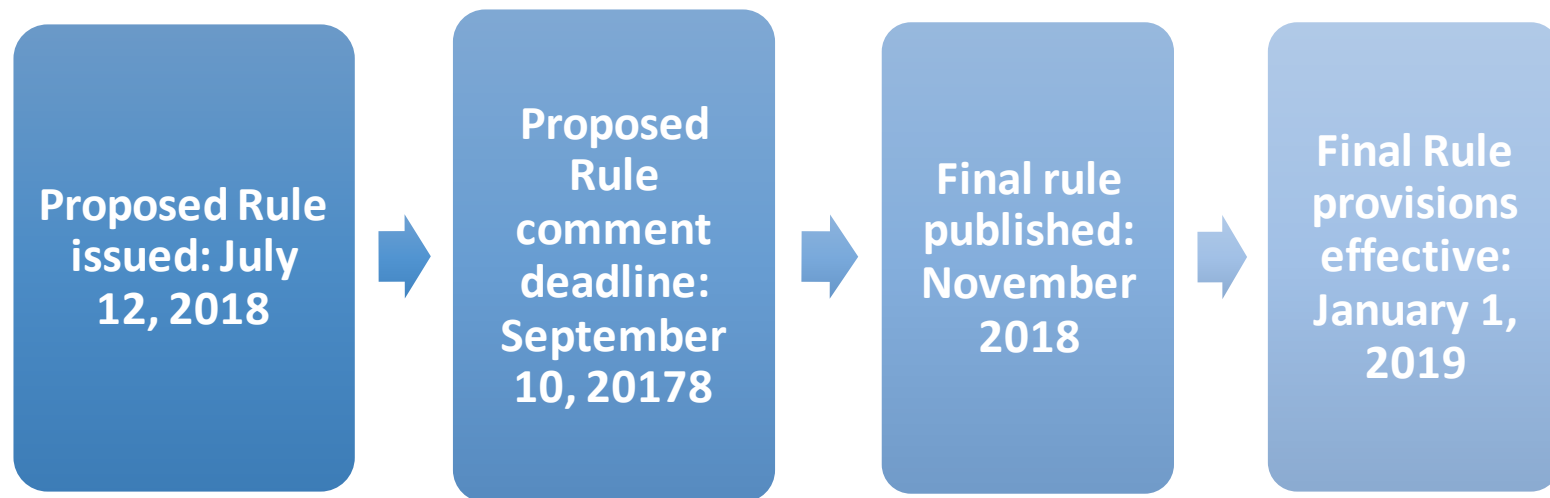
# Agenda

- Payment Policies
  - Physician fee schedule updates, Conversion Factor
- Changes to evaluation & management documentation requirements and payment
  - Single, blended payment for evaluation & management codes levels 2-5
  - Changes to documentation requirements
  - Teaching physician documentation requirements
- FPSC Impact Analysis
- Payment for Communication Technology Services
  - New codes for interprofessional consultation
  - Payment for new virtual check-ins, remote evaluation of pre-recorded patient information.
- Bundled payments for substance-use disorder treatment
- Questions

# 2019 Medicare Physician Fee Schedule Proposed Rule

- Displayed July 12, published in Federal Register July 27
  - <https://www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions>
- Supplemental materials (including RVU data)
  - <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-P.html>

# Physician Fee Schedule (PFS) Proposed and Final Rules Timeline



# Payment Policies

# Physician Fee Schedule Updates

- MACRA repealed Sustainable Growth Rate
- PFS 0.5% update CY 2016-CY 2019
  - Balanced Budget Act of 2018 changed update to 0.25% for 2019
- PFS 0.0% update CY 2020-2025
- PFS updates 2026 and beyond: 0.75% for APM; 0.25% for MIPS
- QPP program will drive payment in 2019 and beyond

# Calculation of 2019 PFS Conversion Factor



<b>Conversion Factor 2018</b>		<b>\$35.9996</b>
Statutory Update Factor	0.25 percent (1.0025)	
2019 RVU Budget Neutrality Adjustment	-0.12 percent (0.9988)	
<b>2019 Conversion Factor</b>		<b>\$36.0463</b>



# Changes to Evaluation and Management (E/M) Codes and Documentation Requirements



# Eliminating Extra Documentation Requirements for Home Visits

- CMS is proposing 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, CMS prohibits payment for two E/M visits billed by a physician (or physician in the same practice) for the same beneficiary on the same day.
- CMS has proposed eliminating this policy.

# Proposed Changes to Documentation Requirements

- Physicians will be allowed to choose the method of documentation:
  1. 1995 or 1997 Evaluation & Management Guidelines for history, physical exam, and medical decision making (current framework)
  2. Medical decision making only
  3. Physician time spent face-to-face with patients

# Removing Redundancy in E/M Visit Documentation

- CMS proposes to expand the current policy that the billing provider is not required to repeat the documentation for “Review of Systems” and/or pertinent past, family, or social history (PFSH) obtained during an earlier encounter.
- If there is evidence that the provider reviewed/updated the information, they would not need to re-record the elements.

# Removing Redundancy in E/M Visit Documentation

- CMS proposes to remove the requirement of re-documenting the chief complaint and history of present illness.

# Teaching Physician Documentation for E/M Services

- CMS proposes to revise regulations that require medical records to document that the teaching physician was present at the time of service.
- The presence of a teaching physician during the E/M service may be demonstrated by notes in the medical record made by a physician, resident or nurse.

# Payment Changes for E/M Codes

- CMS is proposing a single, blended payment rate for E/M codes levels 2 through 5 for established patients (99212-99215) and new patients (99202-99205).
- CMS proposes to make other adjustments through add-on payments and MPPR for payment accuracy.

# Payment Changes for E/M Codes



CPT	CY 2018 Non-facility payment rate	Proposed CY 2019 Non-facility payment rates
99201	\$45	\$44
99202	\$76	\$135
99203	\$110	
99204	\$167	
99205	\$211	

CPT	CY 2018 Non-facility payment rate	Proposed CY 2019 Non-facility payment rates
99211	\$22	\$24
99212	\$45	\$93
99213	\$74	
99214	\$109	
99215	\$148	



# Payment Changes for E/M Codes

99202-99205

New Patient

Work RVU: 1.90

Physician time: 37.39 min

Direct PE: \$24.98

99212-99215

Established patient

Work RVU: 1.22

Physician time: 31.31

Direct PE: \$20.70

## Time as Basis of Payment

- CMS is soliciting comments on what total time should be used for the new single, blended payment rate for E/M codes levels 2-5, if time were to be the basis of payment.

# Time as Basis of Payment: Proposed Options

- CPT codebook provision: for timed services, a unit of time is attained when the midpoint is passed (e.g. 16 minutes for established patients, 20 minutes for new patients).
- Require documentation that the typical time for the CPT code is spent face-to-face with the patient (e.g. 10 minutes for 99212, 25 minutes for 99214).

# New Add-on Codes for E/M Services

- Along with the changes to a single payment rate for E/M codes levels 2-5, CMS has proposed three new add-on G-codes.

# New Add-on G-code: Primary Care

## GPC1X

Visit Complexity inherent to E/M associated with **primary care services** that serve as the continuing focal point for all needed health care services

Work RVU: 0.07

Physician time: 1.75 minutes

PE RVU: 0.07

MP RVU: 0.01

Payment: Approximately \$5

# New Add-on G-code: Specialty Care

## GCG0X

Visit complexity inherent to E/M services associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care.

Work RVU: 0.25

Physician time: 0.07

MP RVU: 0.01

Payment: Approximately \$14

# New Add-on G-code: Prolonged Services

## GPRO1

Prolonged E/M or psychotherapy services (List separately in addition to code for office or other outpatient E/M or psychotherapy service )

This would be used for any office visit lasting more than 30 minutes beyond the visit

Work RVU=1.17

Payment: Approximately \$67

## Exclusions

- As 90875 is available to psychiatrists to describe work that might otherwise be reported with a level 4 or 5 E/M visit, CMS proposes that psychiatrists would not be able to use the add-on G-codes.



## E/M Stand-alone and Global Periods Policy (Multiple Procedure Payment Reduction)

- Proposes to reduce payment by 50% for the least expensive procedure/visit that the same physician provides on same day as E&M service; currently using modifier -25.
- CMS notes that the MPPR reductions would be used to fund the new add-on payment for E/M codes.

# Patient Relationship Modifiers

- CMS is considering using voluntarily submitted patient relationship modifiers to adjust payment for E/M visits to the extent that these codes are indicative of differentiated resources provided in E/M visits.

# Changes to Coding and Payment for Podiatric Services

- CMS is proposing that podiatrists would no longer bill using the evaluation and management codes, they would instead use newly established G-codes to bill for those services.

# Discussions on E/M Coding/Documentation Changes

- Having three levels of E/M codes, instead of two.
- De-coupling E/M documentation changes from E/M payment changes.

# New Podiatric G-Codes

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**GPDOX** Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, new patient.

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Work RVU: 1.35

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Physician time: 28.11 min

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Direct PE=\$22.53

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Payment=Approximately \$102

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**GPD1X** Podiatry services, medical examination and evaluation with initiative of diagnostic and treatment program, established patient.

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Work RVU: 0.85

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Physician time: 21.60 min

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Direct PE: \$17.07

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Payment: Approximately \$67

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## Implementation

- CMS is proposing new policies would be implemented Jan 1, 2019, but notes it considered a multi-year or delayed effective date.

# FPSC Analytics Results

## Questions to Answer

1. What is the impact of the blended E/M CPT code proposal to organizations and specialties?
2. How will fee schedule changes to misvalued and revalued codes affect Work RVU and revenue?
3. How great of an effect will the Multiple Procedure Payment Reduction (MPPR) proposal have?
4. To what degree will organizations likely benefit from the add-on code for 30 minutes of extended time for E/M?



# FPSC Modeling of the Proposed Rule

- Using the most recent 12 months of data for each organization, we modeled the effects of the proposed rule changes. Units of service had modifier adjustments applied.
- 2019 fee schedule values came from CMS' Addendum B file.
- We calculated 2018 and 2019 Total RVUs using facility and non-facility Practice Expense RVUs and multiplied that times the conversion factor for each year.

# Blended E/M Codes and Add-ons for Complex Specialty and Primary Care

# New and Established Patient Visit Proposed Blended Payment Rates



New Patient Visits	2018 Facility Payment	2019 Facility Payment	2018 Non-Facility Payment	2019 Non-Facility Payment
99201	27.36	25.59	45.36	43.26
99202	51.48	102.37	76.32	134.45
99203	78.12	102.37	109.80	134.45
99204	131.76	102.37	167.40	134.45
99205	172.08	102.37	210.60	134.45
Established Patient Visits				
99211	9.36	9.73	21.96	24.15
99212	25.92	65.60	44.64	91.92
99213	52.20	65.60	74.16	91.92
99214	79.92	65.60	109.44	91.92
99215	113.04	65.60	147.60	91.92

*The 2018 average payment for 99202-99205 in the facility setting was \$108.36, the blended rate is \$102.37. In the non-facility setting, the average rate is \$141.03 and the blended rate is \$134.45.*

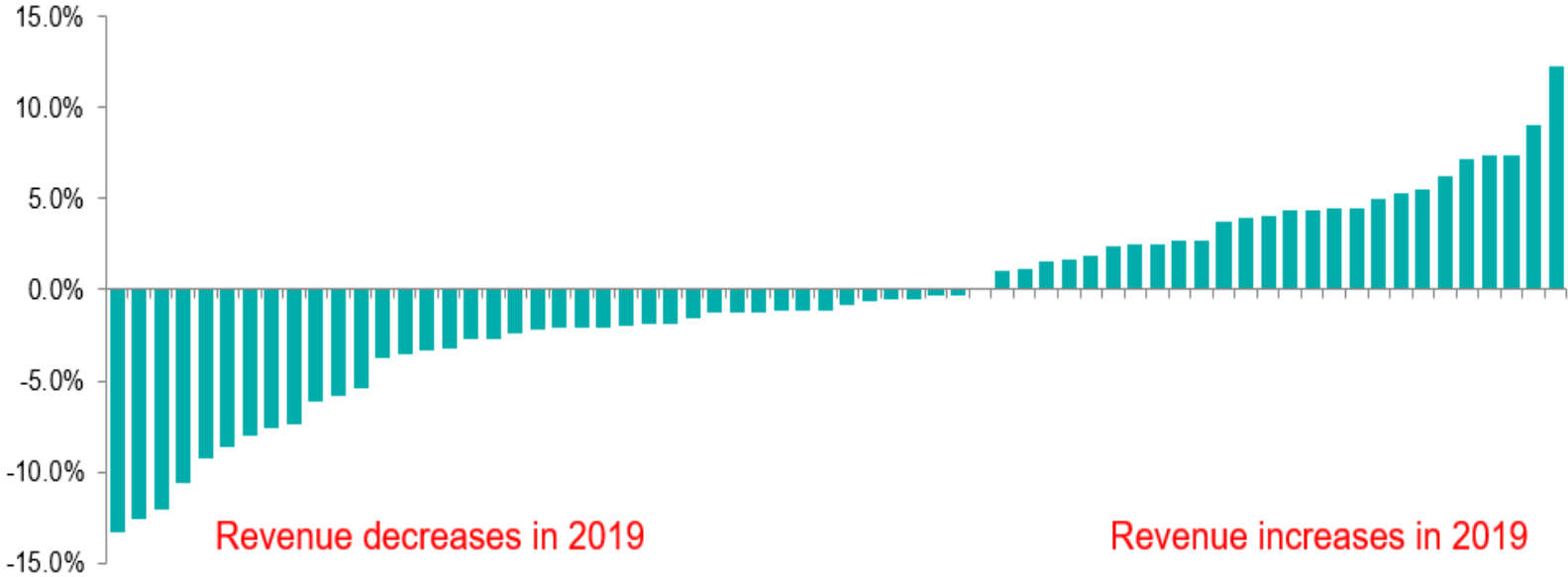
*For 99212-99215 the average rate for facility payments in 2018 was \$67.77 and the blended rate is \$65.60. For non-facility visits the 2018 average was \$93.96 and the blended rate is \$91.92.*



# For blended E/M services, the net payment differences show mixed results

More organizations with net losses than gains.

### 2018 - 2019 E/M Payment Variance by Organization



CPT Codes 99201-99205 and 99210-99215 (including Podiatry changes and Complex Specialty and Primary Care Add-ons). Does not include Multiple Procedure changes.

## New add-on codes supplement payment for complex medical specialty visits and primary care

- HCPCS code **GCG0X** – Visit complexity inherent to certain specialist visits
- HCPCS code **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

These codes would be billed in addition to the E/M code for the service performed.

*CMS also advised: “We also wish to be clear that we are proposing to retain the current CPT coding structure for E/M visits (along with creating new replacement codes for podiatry office/outpatient E/M visits) ... Practitioners would report on the professional claim whatever level of visit (1 through 5) they believe they furnished using CPT codes 99201-99215.”*

# FPSC specialties that received the GCG0X complexity add-on



The payment will be \$13.70 per instance for either new or established levels 2 through 5 E/M codes in the facility or non-facility setting.

Allergy / Immunology	Medical Oncology with Infusion	Pediatrics: Hematology / Oncology
Ambulatory Gynecology	Medical Oncology without Infusion	Pediatrics: Neurology
Cardiology: Electrophysiology	Midwifery	Pediatrics: Otorhinolaryngology
Cardiology: General	Neurology: <u>Alzheimers</u> / Dementia	Pediatrics: Rheumatology
Cardiology: Invasive	Neurology: Epilepsy / EEG	Pediatrics: Urology
Cardiology: Invasive Interventional	Neurology: General	Physical Medicine: Pain and Spine
Cardiology: Noninvasive	Neurology: Neuromuscular	Reproductive Endocrinology
Endocrinology / Metabolism	Neuropsychology	Rheumatology
Gynecological Oncology	Obstetrics / Gynecology	Sleep Medicine
Gynecology	Otorhinolaryngology	Surgical Oncology
Hematology	Pain Management	Uro-Gynecology
Maternal and Fetal Medicine	Pediatrics: Endocrinology	Urology

We used the Medicare specialty designations found in the utilization files and cross-walked those to FPSC specialties. Specialties are designated in: CMS-1693-P\_2017\_Utilization\_Data\_Crosswalked\_to\_2019.xls



## FPSC specialties that received the GPC1X primary care add-on in our model

- **The payment as proposed is \$3.97 in the facility setting and \$5.41 in the non-facility setting per instance for either new or established levels 2 through 5 E/M codes.**
  - Family Medicine (without OB)
  - Family Medicine (with OB)
  - General Internal Medicine
  - Geriatrics
  - General Internal Medicine -- Non MD
  - Geriatrics – Non MD
  - Family Medicine – Non MD
  - Unspecified Advanced Practice Providers in departments designated as “Primary Care”

# Impact of blended E/M codes by specialty (payment change for new and established visits)

Specialty areas with **largest percentage revenue loss** for the target E/M Services.

Specialty or Grouping	FPSC Variance	Specialty or Grouping	FPSC Variance
Palliative Care	-24.4%	Radiation Oncology	-13.3%
Nephrology	-22.6%	Geriatrics	-13.2%
All Medical Oncology	-21.4%	Transplant Surgery: All	-10.2%
Surgery: Cardiac	-19.4%	Neurology (All specialties)	-9.4%
Critical Care	-18.6%	Hematology	-8.9%
Pulmonary Disease	-18.6%	Surgery: Thoracic	-8.5%
Hospitalists	-17.3%	Physical Medicine	-7.4%
Gastroenterology / Hepatology	-14.5%	Psychiatry	-6.6%
Infectious Disease	-14.4%	Surgery: Breast	-4.0%

CPT Codes 99201-99205 and 99210-99215 (includes Complex Specialty and Primary Care Add-ons, excludes MPPR)



# Impact of blended E/M codes by medical specialty (payment changes for new and established visits)



Specialty areas with largest percentage revenue gains for target E/M services.

Specialty or Grouping	FPSC Variance	Specialty or Grouping	FPSC Variance
Otorhinolaryngology	24.2%	Surgical Oncology	11.2%
Orthopedic Surgery: Hand	20.6%	Ophthalmology: Optometry	7.4%
Surgery: Plastic	20.5%	Surgery: Neurological	6.5%
Obstetrics / Gynecology (All specialties)	19.8%	Emergency Medicine	4.7%
Surgery: Oral	19.1%	Surgery: General	4.4%
Dermatology (All specialties)	18.8%	Cardiology: Invasive Interventional	4.0%
Urology	17.2%	Surgery: Colon and Rectal	4.0%
Surgery: Trauma	14.0%	Cardiology: Electrophysiology	2.3%
Surgery: Vascular	12.9%	Radiology: Interventional	1.8%
Orthopedic Surgery: All Specialties	12.9%	Gynecological Oncology	1.8%
Pain Management	11.3%	Physical Medicine: Pain and Spine	1.4%

CPT Codes 99201-99205 and 99210-99215 (includes Complex Specialty and Primary Care add-ons, excludes MPPR)



# Multiple Procedure Payment Reductions for visits on day of zero-day global procedures

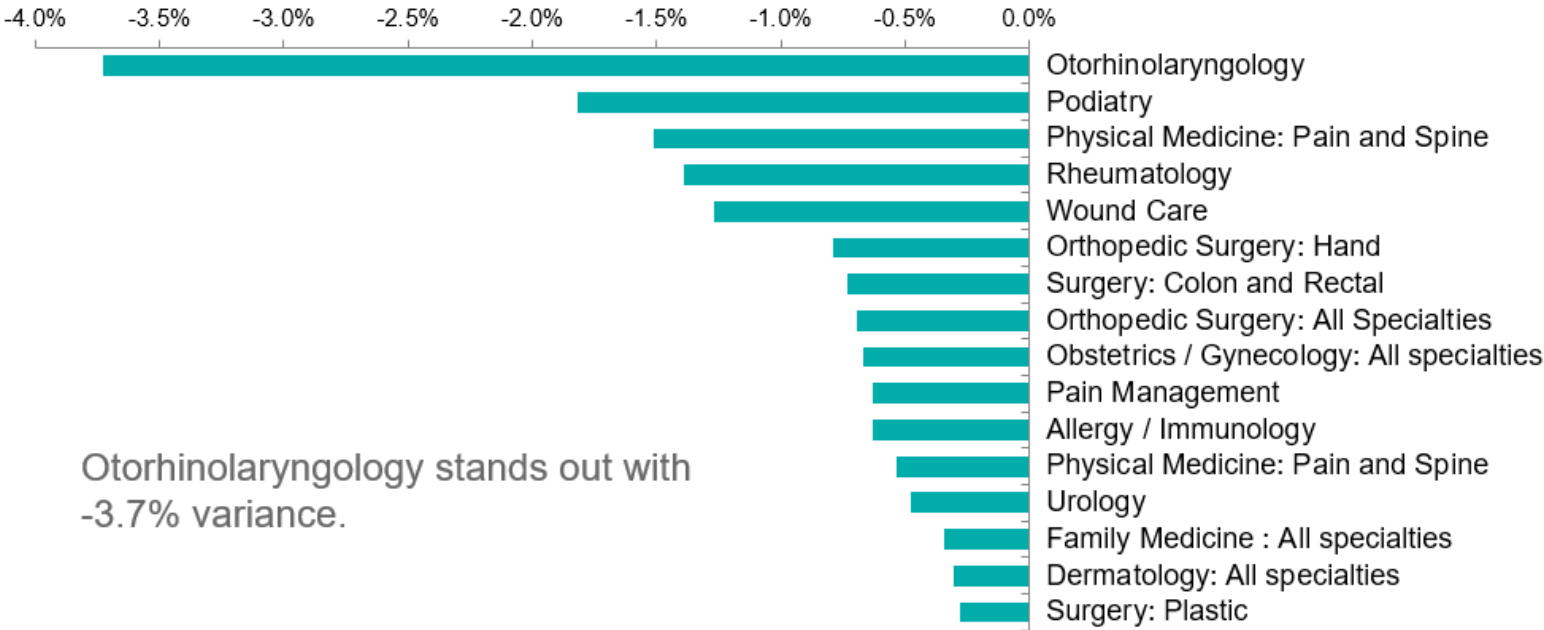
## Multiple Procedure payment reduction for procedures performed the same day as a separately billed E/M code

*“Using the surgical MPPR as a template, we are proposing that, as part of our proposal to make payment for the E/M levels 2 through 5 at a single PFS rate, we would 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 1693-P p. 353*

We applied the logic to patients who received a zero global day procedure and one of the 10 new and established CPT Codes on the same day. Payment amounts were ranked and the lowest paid procedure had its payment reduced by 50%.

# Overall MPPR impact was low

### Total Payment Variance with MPPR by Specialty



Otorhinolaryngology stands out with -3.7% variance.

## MPPR percentage change low but revenue change still significant

On average we are finding that the MPPR proposal represents .2% negative change to revenue at the organization level.

In terms of dollars lost however, this number is significant with some members reaching losses of \$500,000. On average, the MPPR adjustments cost organizations \$130,000 per year.

# Fee schedule changes for misvalued and revalued CPT codes

## Work RVU values showed few changes

Other than new and established visits, we found just 62 CPT Codes with Work RVU changes.

The largest group of codes within this list are Radiology, but other codes appear in the activities performed by Cardiologists, Oncologists, Ophthalmologists and Pathologists as well.

Working through these changes we did not find that the changes represented large variation for providers or for a likely impact on productivity benchmarks.

# Other fee schedule payment changes

- Considering the CPT Codes not affected by the blended E/M proposal, we found that the fee schedule changes in all RVU components represented a relatively small increase in payments at the organization level.
- The average across organizations was a .4% increase in payments and the range was -.6% to +1.3%.
- However, due to Practice Expense and/or Malpractice RVU changes, several specialties saw payment losses.

Specialty	2018-2019 payment variance
Allergy / Immunology	-13%
Medical Oncology w Infusion	-10%
Hematopathology	-7%
Otorhinolaryngology	-4%
Dermatology	-3%
MOHS Surgery	-3%

These changes are isolated to fee schedule changes to practice expense and malpractice RVUs



# New Prolonged Service CPT Code GPRO1

## CMS has proposed adding a code for 30 minutes of additional time spent in direct patient contact

*“...We are proposing HCPCS code GPRO1 (Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; 30 minutes... which could be billed with any level of E/M code.” CMS 1693-P p. 244*

The facility payment would be \$63.08 and the non-facility rate would be \$67.41.

CMS proposes that the physician typical time be 31 minutes for all of the established patient visits (2-5) and 38 minutes for the new patient visits (2-5). This suggest that the visit would need to be 68 minutes for new patients 61 minutes for established patients to be able to bill GPRO1.

## A rough model for GPRO1

For our rough model, we assume new patient visits lasting 68 minutes or established patient visits lasting 61 minutes would have been billed at a level 5 in our 12-month data set. The approach simply takes a set percentage of those level 5 codes and applies the GPRO1 payments.

Percent of level 5 codes receiving add-on	2%	5%	10%	15%	20%
Average annual total dollars	\$23,530	\$58,824	\$117,648	\$176,472	\$235,296

The specialties with the highest percentage of level 5 visits from FPSC E/M distribution benchmarks.

Specialty	Percentage at Level 5	Specialty	Percentage at Level 5
Neurology: Neuromuscular	34.7%	Nephrology	28.1%
Bone Marrow Transplant	43.2%	Hematology	27.0%
Hepatology	28.1%	Neurology: General	28.3%
Medical Oncology w Infusion	31.9%	Medical Oncology w/o Infusion	30.6%

# New/Revised Codes for Interprofessional Consultation

# New Codes for Interprofessional Consultation

- CMS proposed payment for two new CPT codes for eConsults, that CMS would cover beginning January 1, 2019.
- CMS will allow payment for 4 revised codes (99446, 99447, 99448, and 99449) for Interprofessional consult services– these include verbal reports).
- Proposal is open for public comment until September 10, 2018.

# Revised Interprofessional Internet Consult 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

**11-20 minutes** of medical consultative discussion and review

99448

**21-30 minutes** of medical consultative discussion and review

99449

**31 minutes or more** of medical consultative discussion and review

# New Interprofessional Consult CPT Codes

994X0

- Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes

994X6

- 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.

# CPT Editorial Panel Guidelines

- **No use** of these codes if **patient sees specialist** within 14 days before or after eConsult
- Only **one use** of the code per patient per 7 days
- Ok for patients **with or without a relationship** with the specialist, if a new or exacerbation of existing problem
- No to be used when “sole purpose” of communication is to arrange a referral for an in-person visit



# Recommended Work Values

CPT Code	RUC Recommended Value	CMS Proposed Value	Median Time
994X0 (PCP)	0.5 Work RVUs	0.5 Work RVUs	18 minutes (intraservice)
994X6 (specialist)	0.7 Work RVUs	0.5 Work RVUs	15 minutes (intraservice); 8 minutes (post-service) (total 23 minutes)

# Primary Care Physician Code-994X0

## Description of intra-service work:

Includes physician work reviewing records, assembling the pertinent materials, developing clinical questions/concerns, and transmitting this information to the appropriate consultant. As needed, the treating/requesting physician directly communicates with the consultant.

# Specialist Code-994X6

## **Description of intra-service work:**

Includes clarifying nature of the patient's problem; obtaining and reviewing data or relevant information; presenting an analysis of the patient's problem, including likely diagnosis and suggested management; responding to questions to clarify diagnostic and treatment approach; relaying relevant scientific background on the diagnosis; outlining suggestions for long-term handling of the patient's problem; completing literature review in response to issues raised during communication.

## **Description of post-service work:**

Includes final review, signing, and sending written report to the treating/requesting physician.

# CMS Questions and Concerns

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Concerned about how these services can be distinguished from activities undertaken for benefit of practitioner (e.g. professional courtesy or continuing education).

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Seeking comment on assumption these are separately identifiable services & how they can be distinguished.

# CMS Questions and Concerns

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CMS seeks comment on how to minimize potential program integrity issues.

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Particularly interested in information on whether these services are paid by private payers & what controls private payers use.

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CMS proposes to require treating practitioner to obtain verbal beneficiary consent in advance of these services (which would be documented in medical record) to ensure patient is aware of service & copay.

# Communication via Technology-based Services

# Brief Communication Technology-based Service, e.g. Virtual Check-in

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## HCPCS GVC11

Brief communication technology based service, e.g. virtual check-in provided 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, not leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minute of medical discussion.

# Virtual Check-ins

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Service billable when physician or qualified health care professional has a brief non-face-to-face check-in with patient via communication technology to assess whether patient's condition necessitates office visit.

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Only furnished for established patients (expect patient to initiate).

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CMS seeks comment on types of communication that would be used (e.g. audio only or video), whether there should be limits on frequency, time frames for separately billable, how to document medical necessity.



## Payment for Virtual Check-ins

### Facility

Total RVU: 0.37

Payment: \$13.34

### Non-facility

Total RVU: 0.42

Payment: \$15.13

# Remote Evaluation of Pre-Recorded Patient Information

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## HCPCS GRAS1

CMS proposes to create specific coding that describes the remote professional evaluation of patient-transmitted information conducted via pre-recorded “store and forward” video or image technology.

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Services are intended to determine whether or not office visit or other service is warranted.

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Can be separately billed if no resulting E/M office visit and no related E/M visit within previous 7 days.

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## Payment for GRAS1

### Facility

Work RVU: 0.28

Payment: \$10.09

### Non-facility

Work RVU: 0.36

Payment: \$12.98

# Bundled Payment for Substance Use Disorder Treatment

# Bundled Payment for Substance Use Disorder (SUD) Treatment

- CMS proposes to make separate payment for a bundled episode for care for management and counseling for substance use disorders.

# Appropriate Use Criteria for Advanced Diagnostic Imaging Services

# Appropriate Use Criteria (AUC) for Advanced Diagnostic Services

Established by the Protecting Access to Medicare Act of 2014

Criteria for physicians to better identify the appropriate advanced diagnostic imaging service:

- AUC must be developed by qualified provider-led entities
- Clinical decision support mechanisms (CDSMs) are electronic tools physicians will use to access the AUC to determine appropriateness of advanced diagnostic imaging test
- Requirement that in the future, ordering physicians must begin consulting CDSMs and furnishing professionals must append AUC information about ordering physician's consultation to Medicare claims
- Identification of outlier physicians in the future

# AUC Implementation

CMS makes the AUC consultation and reporting requirements effective for an educational and operational testing period beginning on January 1, 2020. A voluntary physician participation period will run from mid-2018 through 2019.

In future, payment may only be made if the claim includes the proposed information required by furnishing professionals.

AUC criteria applies across the payment systems (PFS, hospital outpatient, ASC).



# AUC Implementation: What is Required?

## Ordering Professional

- Must consult AUC through qualified CDSMs for tests ordered on or after January 1, 2020
- This is a delay from the statutory requirement of 2017

## Furnishing Professional

- Must report:
  - Which qualified CDSM was consulted by ordering professional
  - Whether service ordered would adhere to AUC or not, or whether AUC not applicable; and
  - NPI of ordering professional

# Proposals for Implementation: 2019

- Revise definition of an applicable setting to add independent diagnostic testing facility (IDTF)
- AUC consultation through a qualified CDSM may be performed by clinical staff working under the direction of the ordering professional (subject to applicable state licensure/scope of practice laws)

# Proposals for Implementation: 2019

- Establish a set of G-codes and HCPCS modifiers to capture AUC consultation information on Medicare claims
- Establish criteria specific to the AUC program for the significant hardship exception are independent of other programs

# Proposals for Part B Drug Payment

## Part B Drugs: Add-on Percentage for Certain Wholesale Acquisition Cost (WAC)-based Payments

- CMS proposes WAC-based payment for Part B drugs made under section 1847A(c)(4) of the Act receive a reduction in payment, from 6% to 3%.

# Changes to Medicare Shared Savings Program (MSSP) Measures

# MSSP: Changes to CAHPS Measure Set

- Proposing to begin scoring two summary survey measures:
  - ACO-45 CAHPS: Courteous and Helpful Office Staff
  - ACO-46: CAHPS: Care Coordination

# MSSP: Changes to Claims-based Quality Measure Sets

- Proposing to retire measures:
  - ACO-35 Skilled Nursing Facility 30 Day All-Cause Readmission Measure
  - ACO-36 All-Cause Unplanned Admissions for Patients with Diabetes
  - ACO-37 All-Cause Unplanned Admissions for Patients with Heart Failure
  - ACO-44 Use of Imaging Studies for Low-back Pain



# MSSP: Changes to QPP Web Interface Measures

## Proposing to Remove

- ACO-12 Medication Reconciliation Post-Discharge
- ACO-13 Falls: Screening for Future Fall Risk
- ACO-15 Pneumonia Vaccination Status for Older Adults
- ACO-16 Preventative Care and Screening: BMI Screening and Follow up
- ACO-41 Diabetes: Eye Exam
- ACO-30 Ischemic Vascular Disease: Use of Aspirin of another Antithrombotic

## Proposing To Add

- ACO-47 Falls: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls (starting 2019)

## Resource Links

- Medicare Physician Fee Schedule Final Rule  
<https://www.gpo.gov/fdsys/pkg/FR-2017-11-15/pdf/2017-23953.pdf>
- CMS Fact Sheet on Medicare Physician Fee Schedule  
<https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-3>
- AAMC Webpage: Physician Payment and Quality  
<https://www.aamc.org/initiatives/patientcare/patientcarequality/311244/physicianpaymentandquality.html>

## Questions and Feedback

- Questions and feedback about PFS Proposed Rule
  - Gayle Lee, [galee@aamc.org](mailto:galee@aamc.org)
  - Kate Ogden, [kogden@aamc.org](mailto:kogden@aamc.org)
- FPSC Projects Related to PFS
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The logo features a blue arc above the text. The text is arranged in three lines: "faculty practice" in bold black, "solutions center" in orange, and "by Vizient and AAMC" in grey below it.

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