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Physician Fee Schedule 2019 Final Rule

December 3, 2018

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Questions and Feedback

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Agenda

- Payment Policies
  - Physician fee schedule updates, Conversion Factor
- Changes to evaluation & management documentation requirements and payment
  - Single, blended payment for evaluation & management codes
  - Changes to 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.
  - Telehealth
- Other Policies
- Questions

2019 Medicare Physician Fee Schedule Final Rule

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- Displayed Nov 1, published in Federal Register Nov 23
  - https://www.federalregister.gov/documents/2018/11/23/2018-24170/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

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Physician Fee Schedule (PFS) Proposed and Final Rules Timeline

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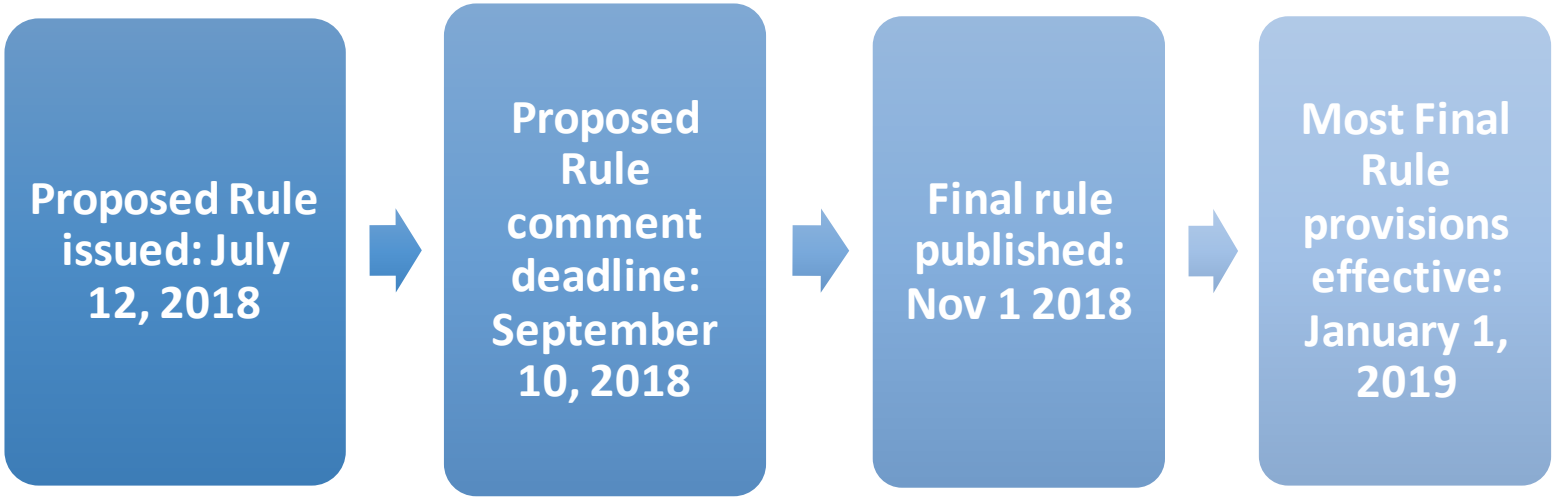

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Payment Policies

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Physician Fee Schedule Updates

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- MACRA repealed Sustainable Growth Rate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 updates in 2019 and beyond

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Calculation of 2019 PFS Conversion Factor

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Conversion Factor 2018		$35.9996
Statutory Update Factor	0.25 percent (1.0025)	
2019 RVU Budget Neutrality Adjustment	-0.14 percent (0.9986)	
2019 Conversion Factor		**$36.0391**

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Changes to Office/Outpatient Evaluation and Management (E/M) Documentation and Payment

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Eliminating Extra Documentation Requirements for Home Visits: Effective 2019

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- CMS finalized their proposal 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

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Eliminating Prohibition on Billing Same-day Visits

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- 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 solicited comments about this policy, but did not finalize any changes.

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Removing Redundancy in E/M Visit Documentation: Effective 2019

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- CMS finalized proposal to expand the current policy that the physician 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 physician reviewed/updated the information, they do not need to re-record the elements.

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Removing Redundancy in E/M Visit Documentation: Effective 2019

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- Finalized proposal to allow practitioners to review and verify certain information (chief complaint and history of present illness in the medical record) that is entered by ancillary staff or the beneficiary, rather than re-entering it.
  - Allows practitioners to focus their documentation on what has changed since the last visit, rather than re-documenting information in the history and exam.

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Teaching Physician Documentation for E/M Services: Effective 2019

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- CMS finalized a revision to 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.

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Finalized Changes to Documentation Requirements: 2021

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- Beginning 2021 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

  (times will be typical face-to face times associated with each code)

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Payment Changes for E/M Codes

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- CMS finalized a single, blended payment rate for outpatient/office E/M codes levels 2 through 4 for established patients (99212-99214) and new patients (99202-99204), beginning Jan. 1, 2021.
- CMS finalized add-on payments for payment accuracy.

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Payment Changes for E/M Codes (Jan. 1, 2021)

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CPT	CY 2018 Non-facility payment rate	Proposed CY 2019 Non-facility payment rates
99201	$45	$44
99202	**$76**	**$130**
99203	**$110**	**$130**
99204	**$167**	**$130**
99205	$211	$211

CPT	CY 2018 Non-facility payment rate	Proposed CY 2019 Non-facility payment rates
99211	$22	$24
99212	**$45**	**$90**
99213	**$74**	**$90**
99214	**$109**	**$90**
99215	$148	$148

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Payment Changes for E/M Codes

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99202-99204	99212-99214
New Patient	Established patient
Work RVU: 1.76	Work RVU: 1.18
Physician time: 34.43	Physician time: 30.26

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New Add-on Codes for E/M Services

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- Along with the changes to a single payment rate for E/M codes levels 2-4, CMS has finalized three new add-on G-codes.

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Add-on Codes for E/M Services

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HCPCS Code	Descriptor	Payment
Inherent complexity for non-procedural specialty care	GCG0X	$13
Primary care (focal point)	GPC1X	$13
Prolonged services	GPRO1	$67

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Descriptors of Add-On Code

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TABLE 22: Finalized Code Descriptors for Visit Complexity Add-ons

HCPCS	Descriptor
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 (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)
GCG0X	Visit complexity inherent to evaluation and management associated with non-procedural specialty care including endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonology. (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established)

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New Add-on G-code: Extended Services

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GPRO1

Extended 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

Payment: Approximately $67

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Minutes Spent on Extended Outpatient Visits

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Established Patient			New Patient		
Level	**Minutes Spent**	**Codes Reported**	**Level**	**Minutes Spent**	**Codes Reported**
1	N/A		1	N/A	
2	34-69	99212/3/4 + extended services G code	2	38-69	99203/4/5+ extended services G code
3			3		
4			4		
5	70+	99215+99354	5	90+	99205+99354

Table 24A

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E/M Payment Changes

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		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)

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Example of Coding

A cardiologist sees a 75 year old female with hypertension, coronary artery disease, and osteoarthritis for routine follow-up care. During the visit, the patient describes a worsening pain in her hip and dizziness for the past month. The clinician notes gait instability and painful motion of her hip, and significant orthostasis upon standing. The clinician observes that the patient has made errors in filling her pill box, and has a new anti-histamine that the patient obtained from her friend to help with sleep. The clinician conducts a brief cognitive test, ascertains that the patient had not fallen, and recommends stopping the anti-cholinergic medication, and adjustment of her blood pressure medications with close follow-up monitoring. In addition to reviewing the patient's cardiac status, initiating imaging to evaluate the hip, the clinician also recommends a home safety evaluation, and schedules a follow-up visit to include her adult daughter who lives nearby.

Example of Coding

- Because the clinician is providing primary care services as well as specialty cardiology services, the physician would report the primary care complexity add-on in addition to the appropriate E/M visit code.

CMS Does NOT Implement Proposed Multiple Procedure Payment Reduction Policy

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- CMS proposed to reduce payment by 50% for the least expensive procedure/visit that the same physician provides on same day as E&M service
- CMS listened to commenters and DID NOT Implement

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Implementation

- CMS will implement the majority of these finalized changes Jan. 1, 2019, except for the changes to E/M payment, which will be implemented Jan. 1, 2021.
- CMS notes that the delay in implementation for some changes will allow for additional time to work with stakeholders and allow the AMA CPT-RUC process to complete.

CMS Engagement with Stakeholders

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- CMS indicates they may refine these E&M policies in future based on discussions with stakeholders
- AAMC is leading National Academy of Medicine Action Collaborative on Streamlining E/M Guidelines
  - Part of the Collaborative on Clinician Well-Being and Resilience
    - Chair: Victor Dzau
    - Co-Chairs: Darrell Kirch and Thomas Nasca
- AMA Initiative: AMA has established CPT/RUC panel to come up with changes to E/M coding structure

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New/Revised Codes for Interprofessional Consultation

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New Codes for Interprofessional Consultation

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- CMS finalized payment for two new CPT codes for eConsults, that CMS will 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.

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Revised Interprofessional Internet Consult Codes

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99446	99447	99448	99449
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	**11-20 minutes** of medical consultative discussion and review	**21-30 minutes** of medical consultative discussion and review	**31 minutes or more** of medical consultative discussion and review

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New Interprofessional Consult CPT Codes

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99452	Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes
99451	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.

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CPT Editorial Panel Guidelines

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- **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
- Not to be used when “sole purpose” of communication is to arrange a referral for an in-person visit

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Recommended Work Values

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CPT Code	RUC Recommended Value	CMS Proposed Value	CMS Finalized Value	Median Time
99452 (PCP)	0.5 Work RVUs	0.5 Work RVUs	0.7 Work RVUs	18 minutes (intraservice)
99451 (specialist)	0.7 Work RVUs	0.5 Work RVUs	0.7 Work RVUs	15 minutes (intraservice); 8 minutes (post-service) (total 23 minutes)

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Primary Care Code-99452

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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.

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Specialist Code-99451

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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.

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Communication via Technology-based Services

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

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HCPCS G2012	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. (Proposed as GVCI1)

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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.

Only furnished for established patients (expect patient to initiate). No frequency limit.

CMS finalized allowing audio-only, real time telephone calls in addition to video.

CMS will require verbal consent from the beneficiary that is noted in the medical record.

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Payment for Virtual Check-ins

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Facility

Total RVU: 0.37

Payment: $13.34

Non-facility

Total RVU: 0.42

Payment: $15.13

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Remote Evaluation of Pre-Recorded Patient Information

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HCPCS G2010	Remove evaluation of recorded video and/or images submitted by the patient (e.g. store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related/M service provided with in the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment (Proposed as GRAS1)
	Services are intended to determine whether or not office visit or other service is warranted.
	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 G2010

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Facility

Work RVU: 0.28

Payment: $10.09

Non-facility

Work RVU: 0.36

Payment: $12.98

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Expansion of the Use of Telehealth: ESRD

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- Individuals with end-stage renal disease (ESRD) receiving home dialysis can choose to receive certain monthly clinical assessments via telehealth after January 1, 2019.
- Renal dialysis facility and the home were added as telehealth originating sites for the ESRD related clinical assessments.

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Expansion of the Use of Telehealth: Stroke

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- Expand the use of telehealth for purposes of diagnosis, evaluation, or treatment of symptoms of an acute stroke.
- Removes restrictions on geographic locations and the types of originating sites where acute stroke telehealth services can be furnished.
- CMS adds mobile stroke unit as a permissible originating site for acute stroke telehealth services. (in addition to hospitals and critical access hospitals)

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Expansion of Use of Telehealth: Substance Use-disorder

- Geographic requirements (ie. rural requirement) does not apply for telehealth services furnished on or after July 1, 2019 to individuals with substance use disorder or a co-occurring mental health disorder.
- Home is a permissible originating site for telehealth services furnished for substance use disorder or co-occurring mental health disorder.

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Payment Rates for Off-Campus HOPDs

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Payment Rates for Off-Campus Provider-Based Departments of Hospital

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- CMS maintains its policy of paying at 40% percent of the OPPS rate for 2019 and beyond for non-excepted services provided in off campus provider based departments.
- In a separate rule (OPPS) CMS expands the application of its “site neutral” payment policy to clinic visit services performed in excepted off-campus provider-based departments. In 2019 a clinic visit (G0463) when furnished in an excepted off-campus PBD will be paid 70% of the OPPS rate. In 2020 and subsequent years, payment will be decreased to 40% of the OPPS rate.

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Appropriate Use Criteria for Advanced Diagnostic Imaging Services

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Appropriate Use Criteria (AUC) for Advanced Diagnostic Services

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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

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AUC Implementation

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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).

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AUC Implementation: What is Required?

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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

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Finalized Changes for Implementation: 2019

- Revised 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).

Finalized Changes for Implementation: 2019

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

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Part B Drug Payment

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

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

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Changes to Medicare Shared Savings Program (MSSP) Measures

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MSSP: Changes to CAHPS Measure Set

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

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MSSP: Changes to Claims-based Quality Measure Sets

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- Finalized retirement of 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 Hearth Failure
  - ACO-44 Use of Imaging Studies for Low-back Pain

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MSSP: Changes to QPP Web Interface Measures

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Finalized removal	Did not finalize addition
• ACO-12 Medication Reconciliation Post-Discharge • 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	• ACO-47 Falls: Screening, Risk Assessment, and Plan of Care to Prevent Future Falls

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6 Month Extension for Participation Agreements

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- CMS finalized a voluntary six month extension for existing ACOs whose participation agreements expire on Dec. 31, 2018
- CMS also finalizes the methodology for determining financial and quality performance for this six month performance period (Jan. 1, 2019-June 30, 2019)

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FPSC Physician Fee Schedule Analysis

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Overview

- We found that the CY2019 CMS Professional Fee Schedule eliminates 94 CPT Codes and establishes 355 new CPT Codes.
- Dropped codes include:
- 29 Category III codes (temporary codes used to identify emerging technology, services, and procedures)
- 23 Category II codes (alphanumeric codes primarily non-physician products, supplies, and procedures)
- 42 Category I CPT Codes
  - 20 Surgical Family Codes
  - 6 Radiology Family Codes
  - 3 Pathology & Laboratory Family Codes
  - 13 Medicine Family Codes

Work RVU changes are minimal

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- Although we can't model situations where a dropped code is cross-walked into multiple levels of replacement codes, we see that for the codes that appear in both 2018 and 2019 fee schedules, organizations should expect little change in Work RVUs.
- The highest WRVU impact was seen in Sleep Medicine but these changes are likely to have less than a 1% change in Work RVUs.

CPT Code	Description	2018 Work RVU	2019 Work RVU
95806	Sleep study unatt&resp efft	1.25	0.93
95970	Analyze neurostim no prog	0.45	0.35
95800	Slp stdy unattended	1.05	0.85

CPT Code 49422 - *Remove Tunneled Intraperitoneal Catheter* has been revalued from 6.29 Work RVUs to 4.0 Work RVUs. This impact is relatively low because it is not a frequently performed procedure. This affects a number of specialties, but most commonly Kidney Transplant.

Most specialties will see little change in Medicare payments

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While many codes saw changes in Practice Expense values, the mixed nature of increases and decreases resulted in very little movement in payments based on the average volumes of codes billed in FPSC specialty benchmarks. Two exceptions were noted:

- Allergy/Immunology
  - 4.1% decrease in payments for the adult specialty
  - A high volume, low value CPT Code, 95004 –Percutaneous allergy skin tests is reduced to .12 Total RVUs from .15 Total RVUs
- Pathology: Hematopathology
  - 3.1% decrease in payments
  - Reduction in Total RVUs for Flowcytometry CPT Codes 88185 (.85 TRVU to .69 TRVU) and 88187 (1.34 TRVU to 1.08 TRVU)

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Evaluation & Management codes see changes to practice expense and malpractice RVUs malpractice RVUs

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CPT Code	CPT Description	2018 Facility Payment	2019 Facility Payment	2018 Non-Fac Payment	2019 Non-Fac Payment
99201	Outpatient visit new	$ 27.36	$ 27.39	$ 45.36	$ 46.49
99202	Outpatient visit new	$ 51.48	$ 51.54	$ 76.32	$ 77.48
99203	Outpatient visit new	$ 78.12	$ 77.48	$ 109.80	$ 109.92
99204	Outpatient visit new	$ 131.76	$ 131.18	$ 167.40	$ 166.86
99205	Outpatient visit new	$ 172.08	$ 171.19	$ 210.60	$ 209.75
99211	Outpatient visit est	$ 9.36	$ 9.37	$ 21.96	$ 23.07
99212	Outpatient visit est	$ 25.92	$ 25.95	$ 44.64	$ 45.77
99213	Outpatient visit est	$ 52.20	$ 51.90	$ 74.16	$ 75.32
99214	Outpatient visit est	$ 79.92	$ 80.01	$ 109.44	$ 110.28
99215	Outpatient visit est	$ 113.04	$ 112.80	$ 147.60	$ 147.76

Practice Expense and Malpractice RVU Components result in some changes for visit payments. Generally changes represent an increase in the non-facility setting, mixed results in the facility setting.

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Impact of RVU changes for new and established patient visits

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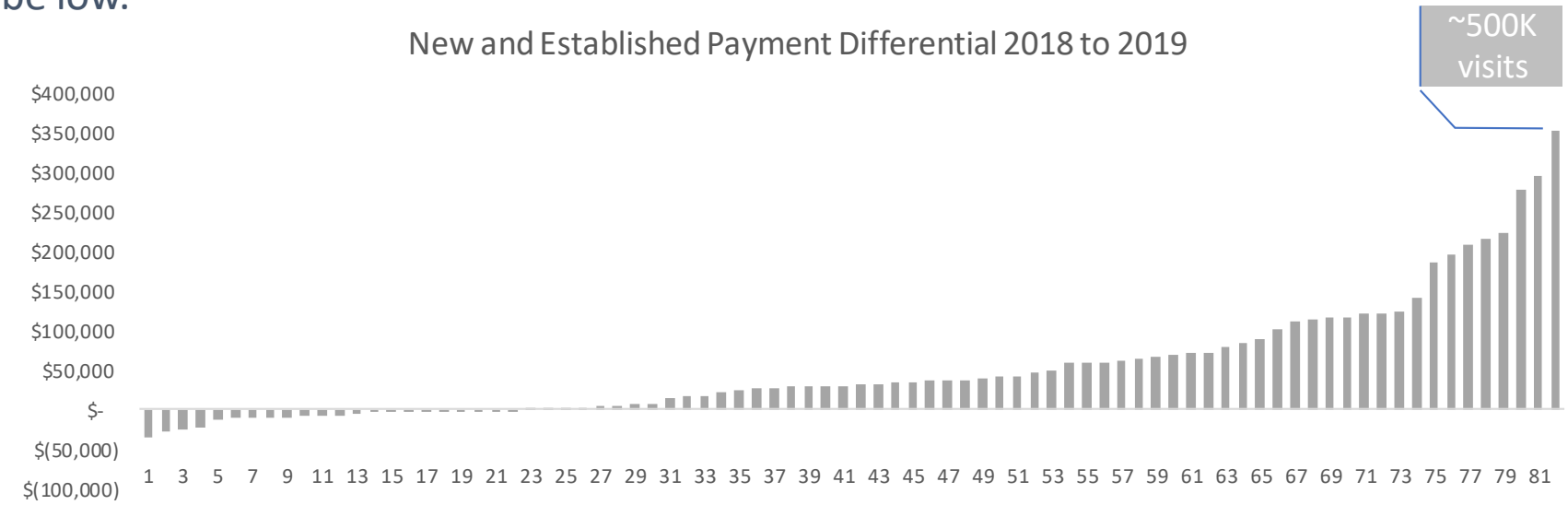
While we are not seeing changes this year for the proposed blending of E&M payments levels, the changes to Total RVUs for visits will result in payment changes for 2019. Based on a recent 12 months of visit data we're seeing a range from -$36,000 to +$350,000 per member. Organization size, coding levels and facility/non-facility billing status drive the differences. At the individual physician level we believe the impact will be low.



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ED visits will be paid just a little more…

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CPT Code	CPT Description	2018 PMT	2019 PMT
99281	Emergency dept visit	$ 21.60	$ 21.62
99282	Emergency dept visit	$ 42.12	$ 42.17
99283	Emergency dept visit	$ 63.00	$ 63.07
99284	Emergency dept visit	$ 119.52	$ 119.65
99285	Emergency dept visit	$ 176.04	$ 176.23

This represents an increase in revenue, but the impact is low, just .1% per organization. The average revenue increase is $12,626 per organization.

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Communication technology-based services

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- Practitioners will be paid for the brief communication technology-based service when the patient checks in with the practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed.

CPT Code	Description	Work RVUs	Facility Payment	Non-Facility Payment
G2010	Brief communication technology-based service, e.g. virtual check-in	0.18	$9.37	$12.61
G2012	Remote evaluation of recorded video and/or images submitted by an established patient	0.25	$13.33	$14.78

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Prolonged service codes for Telehealth

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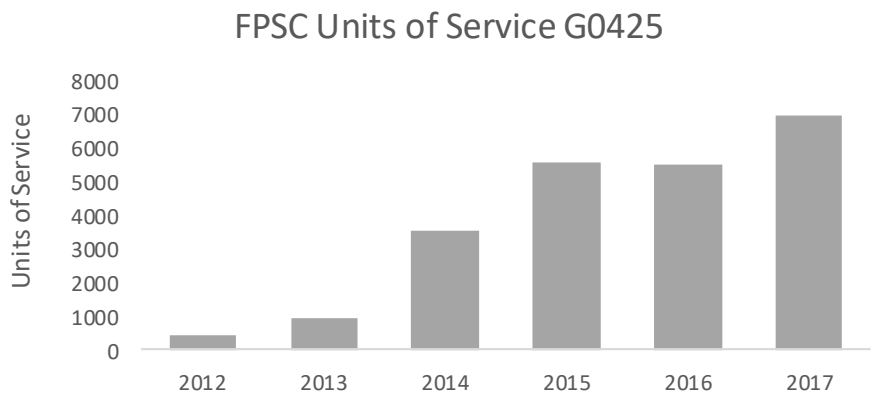
- CMS has added codes G0513 and G0514 to the list of telehealth services.

CPT Code	Description	Work RVUs	Facility Pmt	Non-Facility Payment
G0513	Prolong prev svcs, first 30m	1.17	$62.35	$65.95
G0514	Prolong prev svcs, addl 30m	1.17	$62.35	$65.95

The number of new codes (many replacing temporary codes, accounting for new technologies, and creating additional granularity) will be a challenge to coding and charge capture. Adoption rates tend to be gradual.



This graph demonstrates what we've observed for the Telehealth consultation code G0425 over time.

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New codes available for CNS testing and neuropsychological testing

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New CPT codes were added to the Central Nervous System Assessments/Tests. 96112 and 91113 for developmental test administration based on time. Add on code 96121 for a neuro behavioral status examination for ab additional hour. Under Testing Evaluation Services CPT codes 96130-96133 were added for neuropsychological testing evaluation services based on time.

96136-96139 were added to report psychological or neuropsychological report testing and scoring. Codes are based on time and whether the service was performed by a technician or clinician.

CPT code 96146 is used to report psychological or neuropsychological automated testing using an electronic platform.

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Payments for new testing codes

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CPT Code	Description	Work RVU	Facility Payment	Non-Facility Payment
96130	Psycl tst eval phys/qhp 1st	2.56	$111.72	$118.93
96131	Psycl tst eval phys/qhp ea	1.96	$85.05	$90.46
96132	Nrpsyc tst eval phys/qhp 1st	2.56	$109.56	$133.71
96133	Nrpsyc tst eval phys/qhp ea	1.96	$83.97	$101.99
96136	Psycl/nrpsyc tst phy/qhp 1st	0.55	$25.23	$47.93
96137	Psycl/nrpsyc tst phy/qhp ea	0.46	$19.82	$44.33
96138	Psycl/nrpsyc tech 1st	0	$38.92	$38.92
96139	Psycl/nrpsyc tst tech ea	0	$38.92	$38.92

New codes for programming a neurostimulator were added with CPT codes 95976-95984. Codes are selected based on the nerve selected and simple versus complex. Eight new CPT codes 97151-97158 and guidelines were added to Adaptive Behavioral services to address deficient adaptive behaviors.

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Fine Needle Aspiration changes

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CPT codes 10021 and 10022 were reviewed and the CPT Editorial Panel deleted CPT code 10022, revised CPT code 10021, and created nine new codes to describe fine needle aspiration procedures with and without imaging guidance.

		2018 Work RVUs	2018 Non-Facility PE RVUs	2018 Facility PE RVUs	2018 MP RVUs
10021	Fna w/o image	1.27	2.03	0.55	0.17
10022	Fna w/image	1.27	2.6	0.48	0.13

		2019 Work RVUs	2019 Non-Facility PE RVUs	2019 Facility PE RVUs	2019 MP RVUs
10021	Fna w/o image	1.03	1.61	0.44	0.14
10022	Fna w/image				

The impact to productivity benchmarks will be very small for the change to 10021. ~60 WRVUs for physicians in the Cytopathology and Endocrinology/Metabolism specialties.

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Imaging changes

- CPT Codes 77058 (Magnetic resonance imaging, breast, without and/or with contrast material(s); unilateral) and 77059 (Magnetic resonance imaging, breast, without and/or with contrast material(s); bilateral) are replaced with 4 new codes.

		2018 Work RVUs	2018 Non-Facility PE RVUs	2018 Facility PE RVUs	2018 MP RVUs
77058	Mri one breast	1.63	0.6	0.6	0.09
77059	Mri both breasts	1.63	0.6	0.6	0.09

		2018 Work RVUs	2019 Non-Facility PE RVUs	2019 Facility PE RVUs	2019 MP RVUs
77046	Mri breast c- unilateral	1.45	0.53	0.53	0.08
77047	Mri breast c- bilateral	1.6	0.59	0.59	0.09
77048	Mri breast c-+ w/cad uni	2.1	0.76	0.76	0.12
77049	Mri breast c-+ w/cad bi	2.3	0.83	0.83	0.13

77059 is more commonly performed than 77058 but neither code appears to be widely used.

Next steps…

- We are beginning FPSC's annual organizational-level Medicare Impact Analyses. The reports detail modeled impact on revenue by applying the Medicare code volumes for a recent twelve months to the new values in the CY2019 fee schedule.
- The changes will only reflect one-to-one code changes. We lack the depth of information needed to perform cross walks when existing codes get replaced by multiple new codes.
- Organizations should expect these reports near year-end.
- We expect to return to modeling the E&M changes planned for 2021 early next year.

Resource Links

- Medicare Physician Fee Schedule Final Rule
  https://www.federalregister.gov/documents/2018/11/23/2018-24170/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions
- CMS Fact Sheet on Medicare Physician Fee Schedule
  https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year
- AAMC Webpage: Physician Payment and Quality
  https://www.aamc.org/initiatives/patientcare/patientcarequality/311244/physicianpaymentandquality.html

Questions and Feedback

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