



CY 2019 Proposed Rule Highlights Radiology Medicare Physician Fee Schedule (MPFS) July 19, 2018

Introductory Summary

On July 12, 2018, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the Medicare Physician Fee Schedule (MPFS) for CY 2019.

MPFS Proposed Rule

The CY 2019 proposed rule is located in its entirety at the following link:

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf>

This document in PDF form is 1473 pages in length. The format of the information is intended to highlight the proposed changes so readers are encouraged to view the document in its entirety for further details

Payment Rates

CY 2019 will still see the conversion factor (CF) impacting reimbursement under the Medicare Physician Fee Schedule (MPFS), but not at the rate increase originally outlined in the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). The Bipartisan Budget Act of 2018 lowered the expected 0.5% increase to 0.25% for CY 2019 from the CY 2018 value. The CF converts relative value units (RVUs) to a dollar amount with regards to reimbursement for billed services. The value of the CF for CY 2019 will directly correlate to the pricing of individual codes reported by physicians and freestanding centers/office settings under the MPFS.

Applying the 0.25% increase to the final CF for CY 2018 of \$35.9996 is not the only adjustment proposed. The CMS budget must be maintained within \$20 million plus or minus each year, when it is projected the impact from any RVU changes will be outside the expected budget. A budget neutrality factor is applied to the CF to bring it back into range and maintain budget neutrality. CMS is proposing a -0.12% adjustment to the CF, which will result in an overall increase in proposed payments for CY 2019, with a proposed value of \$36.0463.

Information regarding the Quality Payment Program for CY 2019 will be provided in a separate summary, which will also impact physician reimbursement.

Table 92 from the proposed ruling outlines the projected impacts:



TABLE 92: Calculation of the Proposed CY 2019 PFS Conversion Factor

CY 2018 Conversion Factor		35.9996
Statutory Update Factor	0.25 percent (1.0025)	
CY 2019 RVU Budget Neutrality Adjustment	-0.12 percent (0.9988)	
CY 2019 Conversion Factor		36.0463

Table 94 reflects the proposed impact for Radiology.

TABLE 94: CY 2019 PFS Estimated Impact on Total Allowed Charges by Specialty*

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
Radiology	\$4,891	0%	0%	0%	0%

** Column F may not equal the sum of columns C, D, and E due to rounding.

Malpractice RVUs

To determine malpractice (MP) RVUs for individual MPFS services, there are three factors considered:

1. Specialty-level risk factors derived from data on specialty-specific MP premiums incurred by practitioners;
2. Service level risk factors derived from Medicare claims data of the weighted average risk factors of the specialties that furnish each service; and
3. An intensity/complexity of service adjustment to the service level risk factor based on either the higher of the work RVU or clinical labor RVU.

Prior to CY 2016, MP RVUs were only updated once every 5 years unless there were new or revised codes introduced. Within the CY 2016 MPFS final rule, CMS set forth the policy to review MP RVUs annually to more accurately represent and evaluate the mix of practitioners providing services on Medicare claims. The new policy would also use 3 years' worth of data, rather than data for a single year.

In CY 2017 the GPCI updated was finalized, which included the updated MP premium data. CMS did not propose to use the updated data for CY 2017 for the specialty risk factors as it was not consistent with the policy finalized in CY 2016. However, CMS did request comments on whether the data should remain unchanged. Based on the comments received CMS considered using the updated MP data to update the specialty risk factors prior to the 5-year update. For CY 2018 rulemaking, CMS considered additional comments received and again decided to not finalize their proposal to update the factors prior to the 5-year update.



At this time, CMS is seeking feedback related to the next update required by CY 2020. In addition, CMS is also requesting comments on improvements regarding how specialties in the state-level raw rate filings data are crosswalked for categorization into the specialty codes used to develop the risk factors and MP RVUs.

Reimbursement

Within the CY 2019 proposed rule publication, CMS addresses quite a few of the misvalued and/or proposed value changes to specific series of CPT® codes. CMS explains the rationale for the proposed changes, values recommended by the Relative Value Scale Update Committee (RUC) and other organizations which CMS looks to for assistance in setting appropriate values for codes.

In reviewing the proposed RVUs for CY 2019, there are obvious sweeping changes to the practice expense (PE) RVUs for most of the CPT® codes. Some changes reflect an increase and others a decrease in the PE RVU value. The proposed changes may be only for the technical component of a service or just the professional, others are adjustments to both. Additionally, there are proposed changes in the malpractice (MP) RVUs for many codes related to radiology services.

CMS only addresses certain radiology families of codes and the proposed rationale for changes within the narrative publication of the rules, as not all of the proposed changes have any rationale to indicate why the values are proposed to be different. There are a significant number of radiology families of codes addressed in the rules. Summaries of each family outlined in the ruling are in the Proposed Valuation of Specific Codes for CY 2019 section below.

Proposed Valuation of Specific Codes for CY 2019

CMS proposed changes or posted requests for comment to several radiology services for CY 2019. Several of the proposed changes included established codes and several outline the proposed values for new CPT® codes yet to be fully released by the American Medical Association (AMA). The following outlines the radiology family of proposed changes to the series of codes specifically addressed by CMS.

Fine Needle Aspiration (CPT® codes 10021, 10X11, 10X12, 10X13, 10X14, 10X15, 10X16, 10X17, 10X18, 10X19, 76942*, 77002 and 77021)

In CY 2014, CPT® code 10021 was identified as part of the Hospital Outpatient Prospective Payment System (HOPPS) cap payment proposal and was reviewed as part of the CY 2016 ruling. The findings were that codes 10021 and 10022 were both referred to the CPT® Editorial Panel to consider adding additional language to the descriptors and to bundle the image guidance, as this is a typical component of the service. The CPT® Editorial Panel deleted code 10022 and created nine new codes effective for CY 2019 to describe fine needle aspiration procedures with and without image guidance. All of the new codes were reviewed in October 2017 and January 2018 meetings. In addition to the new fine needle aspiration codes, several imaging codes were also reviewed; only CPT® code 77021 was reviewed as a new survey.

The new codes for CY 2019 are defined as follows, the full code number will be released by the AMA:



- 10X11 (Fine needle aspiration biopsy; without imaging guidance; each additional lesion),
- 10X12 (Fine needle aspiration biopsy, including ultrasound guidance; first lesion)
- 10X13 (Fine needle aspiration biopsy, including ultrasound guidance; each additional lesion)
- 10X14 (Fine needle aspiration biopsy, including fluoroscopic guidance; first lesion),
- 10X15 (Fine needle aspiration biopsy, including fluoroscopic guidance; each additional lesion)
- 10X16 (Fine needle aspiration biopsy, including CT guidance; first lesion)
- 10X17 (Fine needle aspiration biopsy, including CT guidance; each additional lesion)
- 10X18 (Fine needle aspiration biopsy, including MR guidance; first lesion) and
- 10X19 (Fine needle aspiration biopsy, including MR guidance; each additional lesion)

CMS is proposing to use the RUC recommended work RVUs for seven of the ten codes in this family and assign contractor-priced status to codes 10X18 and 10X19, as these codes will likely have low utilization. Once codes 10X18 and 10X19 have higher utilization, CMS will assign national values.

CMS is proposing to adjust the work RVUs for code 77021 (Magnetic resonance guidance for needle placement (eg, for biopsy, fine needle aspiration biopsy, injection, or placement of localization device) radiological supervision and interpretation) to 1.50 and maintain the current work RVUs for codes 76942 (Ultrasonic guidance for needle placement (eg, biopsy, fine needle aspiration biopsy, injection, localization device), imaging supervision and interpretation) of 0.67 and 0.54 for 77002 (Fluoroscopic guidance for needle placement (eg, biopsy, fine needle aspiration biopsy, injection, localization device)).

CMS did not agree with the RUC recommendations for the work RVU for code 10021 as they believed the proposed value did not reflect the nearly 32% decrease in overall time that was recommended from the review of the code. CMS is proposing a new work RVU of 1.03 for code 10021.

CMS added additional comments regarding the work values and the fact the Fine Needle Aspiration family work pool is increasing to approximately 20%, but the work time pool for the same codes is only increasing about 2%. Time is one of the components of the work RVU and this why CMS believes there are discrepancies in the recommended work values. CMS does not believe the new codes or “recoding” has resulted in an increased intensity, but a change in how codes are reported. This is the reason CMS is not proposing the RUC recommended work RVUs for all of the codes in this family. CMS believes any recoding of a family of services should maintain the same work pool since the services themselves are not changing, just the manner in which they are reported.

*Note in the CY 2019 MPFS proposed ruling the title for this section listed a code number of “76492”, which does not exist, the correct code is 76942. Corrections were made to this summary to accurately reflect the actual CPT® code in the title, which is appropriately discussed by CMS in the body of the section of the publication.



PICC Line Procedures (CPT® codes 36568, 36569, 36X72, 36X73, and 36584)

In CY 2016, code 36569 (Insertion of peripherally inserted central venous catheter (PICC), without subcutaneous port or pump, without imaging guidance; age 5 years or older) was identified as potentially misvalued from the high expenditure screen tool by CMS with Medicare allowed charges of \$10 million or more. It was also identified two imaging codes, 76937 and 77001, were typically billed with the PICC insertion code. CMS referred code 36569 to the CPT® Editorial Panel to bundle in the imaging performed with PICC line placement. In September 2017 the CPT® Editorial Panel did revise codes 36568, 36569 and 36584 and created two new codes specific the insertion of a PICC line. The full definitions are as follows, the full code number will be released by the AMA:

- 36X72 (Insertion of peripherally inserted central venous catheter (PICC) without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; younger than 5 years of age),
- 36X73 (Insertion of peripherally inserted central venous catheter (PICC) without subcutaneous port or pump, including all imaging guidance, image documentation, and all associated radiological supervision and interpretation required to perform the insertion; age 5 years or older)

CMS is concerned about the proposed work RVUs for the new codes by the RUC, given the time decreases of other similar codes in the same family from 71 minutes to 51 minutes for total time, the proposed values are not in alignment with the changes. Additionally, code 36X72 has a lower recommended intraservice time and total time when compared to code 36569, but the RUC recommended a higher work RVU for the new code. CMS is proposing a work RVU of 1.82 for code 36X72 and 1.70 work RVU for code 36X73.

For code 36584, CMS did not agree with the RUC recommendation work RVU of 1.47 and is proposing to maintain the current work RVU of 1.20. This is due to the total time is recommended to decrease from 45 minutes to 34 minutes, which is a 25% reduction and the RUC recommended an increase in the work RVU. Decreases in time are not a one-to-one change in RVUs, but there is a correlation as time is one of the components to the value.

The direct PE inputs for the new codes are proposed by CMS to mirror the other PICC line placement codes of 36568 and 36569, which is 2 minutes of clinical labor time. This clinical labor time value is lower than the RUC recommended value for the new codes.

Radioactive Tracer (CPT® code 38792)

CPT® code 38792 was identified on the screen tool by CMS as having a negative intraservice work per unit time with CY 2016 Medicare utilization of over 10,000 for RUC reviewed codes and over 1,000 for Harvard-valued and CMS/Other source codes. CMS is proposing the RUC recommended work RVU of 0.65 for code 38792. Additionally, CMS is proposing to refine the direct PE inputs for clinical labor time to prep the room, equipment and supplies to three minutes and "Confirm order, protocol exam" to zero minutes. Previously there was no "Confirm order,



protocol exam” time and CMS does not feel the services being furnished have changed, just the manner in which the clinical labor time is presented on the PE worksheets.

Gastrostomy Tube Replacement (CPT® codes 43X63 and 43X64)

The CPT® Editorial Panel created two new codes in September 2017 which describe placement of a gastrostomy tube. The full definitions of the codes are as follows: the full code numbers will be released by the AMA:

- 43X63 (Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; not requiring revision of gastrostomy tract)
- 43X64 (Replacement of gastrostomy tube, percutaneous, includes removal, when performed, without imaging or endoscopic guidance; requiring revision of gastrostomy tract)

The new codes were reviewed by the RUC reviewed in January 2018 for proposed values and submitted to CMS. CMS is proposing work RVUs of 0.75 for 43X63 and 1.41 for 43X64. CMS is also proposing to refine the direct PE inputs of equipment times in accordance with the standard time equipment time formulas.

Dilation of Urinary Tract (CPT® codes 50X39, 50X40, 52334, and 74485)

Since October 2014, there have been coding changes by the CPT® Editorial Panel in the family of codes related to genitourinary catheter procedures. Most recently the CPT® Editorial Panel in September 2017 deleted code 50395 and created two new codes for CY 2019. The new codes are defined as follows: the full code number will be released by the AMA:

- 50X39 (Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, as well as post procedure tube placement, when performed)
- 50X40 (Dilation of existing tract, percutaneous, for an endourologic procedure including imaging guidance (eg, ultrasound and/or fluoroscopy) and all associated radiological supervision and interpretation, as well as post procedure tube placement, when performed; including new access into the renal collecting system)

For new code 50X39, the RUC recommended the same work RVU as the deleted code, but CMS did not agree with this or the reasoning provided by the RUC to support the value. Survey respondents support a total time of nearly 30 minutes less than the existent CPT® code. Instead of the work RVU of 3.37, CMS is proposing a value of 2.78.

For new code 50X40, CMS did not agree with the RUC value of the intraservice time utilization which fell into the 75th percentile, typically the value used is the median. CMS is proposing to reduce the intraservice time value of 60 minutes recommended by the RUC to 45 minutes. CMS does not believe the additional work and time needed to introduce the guidewire into the renal pelvis and/or ureter is supported and not reflected in the values from the survey results.



Additionally, the RUC recommendation is 15 minutes more time than the median for code 50X39. CMS is seeking comments about the time needed to finish the service.

For code 52334, CMS is proposing the RUC recommended value of 3.37 and work RVU of 0.83 for code 74485. CMS is proposing to remove clinical labor time of confirming available or prior studies from code 52334 as it does not include image guidance in the descriptor. Any imaging billed with code 52334, the clinical labor time would be included in the imaging code.

X-Ray Spine (CPT® codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114 and 72120)

CMS identified CPT® codes 72020 and 72072 on the screening tool which found each were utilized for greater than 100,000 services annually. Due to this, CMS opened a review to include an entire family of codes (72020-72080 and 72100-72120) to be evaluated in addition to the codes identified by the screening tool.

The following codes were found to be potentially misvalued through the screen tool identifying them for high utilization. Rather than the specialty society conduct surveys to evaluate the codes, a crosswalk methodology was employed. The derived physician work and time components for the CPT® codes were compared to similar CPT® codes. CMS expressed concerns about the quality of the data used to value the following list of codes, specifically that many of the descriptors and other information has not been surveyed since 1995. Additionally, there is no new information about any of the codes that could potentially detect any possible improvements in furnishing the services or whether even practice patterns have changed. Based on these statements, CMS is not convinced there is any basis to evaluate the RUC's recommendations for work RVUs for the codes listed below and the level of precision about the time as proposed by the RUC cannot be validated. Due to this, CMS is proposing to apply a uniform work RVU of 0.23 to all of the codes listed below. This will be a decrease for some and an increase for others.

- 72020 (Radiologic examination, spine, single view, specify level)
- 72040 (Radiologic examination, spine, cervical; 2 or 3 views)
- 72050 (Radiologic examination, spine, cervical; 4 or 5 views)
- 2052 (Radiologic examination, spine, cervical; 6 or more views)
- 72070 (Radiologic examination, spine; thoracic, 2 views)
- 72072 (Radiologic examination, spine; thoracic, 3 views)
- 72074 (Radiologic examination, spine; thoracic, minimum of 4 views)
- 72080 (Radiologic examination, spine; thoracolumbar junction, minimum of 2 views)
- 72100 (Radiologic examination, spine, lumbosacral; 2 or 3 views)
- 72110 (Radiologic examination, spine, lumbosacral; minimum of 4 views)
- 72114 (Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views)
- 72120 (Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views)
- 72200 (Radiologic examination, sacroiliac joints; less than 3 views)
- 72202 (Radiologic examination, sacroiliac joints; 3 or more views)



- 72220 (Radiologic examination, sacrum and coccyx, minimum of 2 views)
- 73070 (Radiologic examination, elbow; 2 views)
- 73080 (Radiologic examination, elbow; complete, minimum of 3 views)
- 73090 (Radiologic examination; forearm, 2 views)
- 73650 (Radiologic examination; calcaneus, minimum of 2 views)
- 73660 (Radiologic examination; toe(s), minimum of 2 views)

CMS is not proposing any interservice clinical labor time changes, but has concerns since the codes above have not changed in approximately 20 years. CMS believes there have been enough technological advances that have resulted in greater efficiency in providing the radiological exams that values would have changed. CMS is seeking comments on additional details for data sources of the codes in question.

X-Ray Sacrum (CPT® codes 72200, 72202, and 72220)

CPT® code 72220 was identified on the screen tool by CMS as having a Medicare utilization of over 100,000 services annually. Since this code is part of a family of codes, all of the codes are reviewed as well. The same work RVUs as codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, and 72120 for the spine are proposed for the sacrum. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

X-Ray Elbow-Forearm (CPT® codes 73070, 73080, and 73090)

CPT® code 73070 was identified on the screen tool by CMS as having a Medicare utilization of over 100,000 services annually. Since this code is part of a family of codes, all of the codes are reviewed as well. The same work RVUs as codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, and 72120 for the spine are proposed for the elbow. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

X-Ray Heel (CPT® code 73650)

CPT® code 73650 was identified on the screen tool by CMS as having a Medicare utilization of over 100,000 services annually. The same work RVUs as codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, and 72120 for the spine are proposed for the heel. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

X-Ray Toe (CPT® code 73660)

CPT® code 73660 was identified on the screen tool by CMS as having a Medicare utilization of over 100,000 services annually. The same work RVUs as codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, and 72120 for the spine are proposed for the toe. CMS is also proposing to refine the direct PE inputs by adding a patient gown supply to code 73660. This would follow other x-ray code families that also have a gown supply factored into the clinical labor time for greeting the patient, providing a gown and reviewing appropriate



medical records. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

X-Ray Esophagus (CPT® codes 74210, 74220, and 74230)

CPT® code 74220 was identified on the screen tool by CMS as having a Medicare utilization of over 100,000 services annually. Since this code is part of a family of codes, all of the codes are reviewed as well. CMS is proposing to use the work RVUs recommended by the RUC with values of 0.59 for code 74210, 0.67 for code 74220 and 0.53 for code 74230.

CMS is also seeking comments regarding the changes seen with the quantity of Polibar barium suspension. The data indicates the quantity is increasing from 1 ml to 150 ml with CPT® code 74210 and 100 ml is being added to CPT® code 74220, which did not previously include the supply. The RUC recommendations state the increase in quantity of the supply is medically necessary, but does not provide detail about the typical use. CMS is not proposing to refine the quantity of the Polibar barium suspension, CMS is seeking comments about typical use. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

X-Ray Urinary Tract (CPT® code 74420)

CPT® code 74420 was identified on the screen tool by CMS as having a Medicare utilization of over 100,000 services annually. CMS is proposing the RUC recommended work RVU of 0.52, but is proposing to remove one minute from the clinical labor time for the “Confirm order, protocol exam” activity. CMS does not believe there is data to support the need to add this value as it is not part of many of similar codes that were reviewed as part of the RUC meeting. Therefore, CMS is proposing to remove it so it will match the rest of the codes. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

Fluoroscopy (CPT® code 76000)

CPT® code 76000 was identified on the screen tool by CMS as having a Medicare utilization of over 100,000 services annually. Since this code is part of a family of codes, code 76001 was also included in the review; however, due to fact supervision and interpretation are being bundled more and more into procedure codes, the RUC concluded the procedure represented by code 76001 is rare and nearly obsolete. Code 76001 has been recommended for deletion by the CPT® Editorial Panel for CY 2019.

CMS is proposing a work RVU of 0.30 for CPT® code 76000 and to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

Echo Exam of Eye Thickness (CPT® code 76514)

CPT® code 76514 was identified on the screen tool by CMS as having a negative intraservice work per unit time with CY 2016 Medicare utilization of over 10,000 for RUC reviewed codes and over 1,000 for Harvard-valued and CMS/Other source codes. CMS does not agree with the



values proposed by the RUC for the work RVU and is proposing a lower value of 0.14. The intraservice time for code 76514 is decreasing from 5 minutes to 3 minutes and the total time for the code is decreasing from 15 minutes to 5 minutes. The RUC recommendations did not decrease the work RVU even though the times decreased. For this reason, CMS could not accept the RUC recommended value.

Additionally, recommendations by the RUC indicated the steps to the procedure have not changed since it was first valued; the workflow has. Due to the advancement of the pachymeters, which are smaller and easier to use, the technician typically takes the measurements instead of the practitioner. This change in the work performed reduced the intraservice time by two minutes, thus supporting a reduction in value. There are no proposed direct PE changes for this code.

Ultrasound Elastography (CPT codes 767X1, 767X2, and 767X3)

The CPT® Editorial Panel added three new codes for CY 2019 in the September 2017 meeting, describing ultrasound elastography to assess organ parenchyma and focal lesions which would be applied for preparing patients with disease of solid organs. The new codes are defined as follows; the full code number will be released by the AMA:

- 767X1 (Ultrasound, elastography; parenchyma),
- 767X2 (Ultrasound, elastography; first target lesion) and
- 767X3 (Ultrasound, elastography; each additional target lesion).

CMS is proposing to accept the RUC recommended work RVU values of 0.59 for codes 767X1 and 767X2 and 0.50 for add-on code 767X3. CMS is also proposing direct PE input values to reflect a clinical labor time for the prep of room, equipment and supplies to three minutes and the “Confirm order, protocol exam” to zero minutes for codes 767X1 and 767X2. CPT® code 76700 (Ultrasound, abdominal, real time with image documentation; complete) was used for reference for the two new codes, 767X1 and 767X2. Since code 76700 did not have any assigned value for the “Confirm order, protocol exam”, CMS did not believe a value was needed for the new codes.

Ultrasound Exam – Scrotum (CPT code 76870)

CPT® code 76870 was identified on the screen tool by CMS as having a Medicare utilization of over 100,000 services annually. CMS is proposing the RUC recommended work RVU of 0.64. Similar to the new codes for ultrasound (US) elastography, CMS is proposing direct PE input changes for clinical labor time for the prep of room, equipment and supplies to three minutes and the “Confirm order, protocol exam” to zero minutes. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

Contrast-Enhanced Ultrasound (CPT® codes 76X0X and 76X1X)

The CPT® Editorial Panel added three new codes for CY 2019 in the September 2017 meeting to describe evaluating suspicious lesions of intravenous microbubble agents by ultrasound. The new codes are defined as follows; the full code number will be released by the AMA:



- 76X0X (Ultrasound, targeted dynamic microbubble sonographic contrast characterization (noncardiac); initial lesion) is a stand-alone procedure for the evaluation of a single target lesion.
- 76X1X (Ultrasound, targeted dynamic microbubble sonographic contrast characterization (non-cardiac); each additional lesion with separate injection)

CMS did not agree with the values proposed by the RUC for these two new codes and did not believe the rationale were appropriate for how the recommended values were calculated. CMS is proposing different work RVUs of 1.27 for code 76X0X and 0.85 for add-on code 76X1X, these both have a total time of 30 minutes and 20 minutes of intraservice time. Similar to the new codes for US elastography, CMS is proposing direct PE input changes for clinical labor time for the prep of room, equipment and supplies to three minutes and the “Confirm order, protocol exam” to zero minutes.

CMS is proposing to remove the 50 ml of phosphate buffered saline for the new codes. Both CMS and the RUC had agreed to remove this supply when reviewing the code, but it was included in the recommended direct PE inputs, CMS believes this was a clerical error, but is soliciting comments on this. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

Magnetic Resonance Elastography (CPT® code 76X01)

There is a new stand-alone code for CY 2019 for the use of magnetic resonance (MR) elastography. CMS indicated it would be used to evaluate organ parenchymal pathology and most often on patients with disease of solid organs or pathology within solid organs which manifest from increasing fibrosis or scarring. The full descriptor of code 76X01 is (Magnetic resonance (eg, vibration) elastography) and CMS is proposing work RVU of 1.10 with 15 minutes of intraservice time and 25 minutes total time. The work RVUs are not in agreement with the RUC recommended values as CMS felt the RUC overvalued the code and its complexity.

CMS is proposing direct PE inputs of clinical labor time to prep the room, equipment and supplies of five minutes instead of six and the “Prepare, set-up and start IV, initial positioning and monitoring of patient” of three minutes rather than four. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

Computed Tomography (CT) Scan for Needle Biopsy (CPT® code 77012)

CPT® code 77012 was identified on the screen tool by CMS or Other source codes with Medicare utilization greater than 100,000 services annually. CMS did accept the RUC recommended work RVU of 1.50. CMS is proposing to refine the room, supply and equipment prep to three minutes and refine the clinical labor time for “Confirm order, protocol exam” to zero minutes. The code did not previously have any clinical labor time assigned for “Confirm order, protocol exam” and CMS believes the services provided by staff have not changed.



CMS is proposing to continue the equipment time for the CT room at nine minutes. It has been a longstanding application when radiological supervision and interpretation is part of a code the direct PE inputs, shared by 38 other codes, all use nine minutes for equipment room in the procedures. If CMS were to adjust the equipment time for code 77012, it would have to adjust all of the codes with radiological supervision and interpretation and will look at making any changes when the entire group can be reviewed as part of a more comprehensive review. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

Dual-Energy X-Ray Absorptiometry (CPT® code 77081)

CPT® code 76514 was identified on the screen tool by CMS as having a negative intraservice work per unit time with CY 2016 Medicare utilization of over 10,000 for RUC reviewed codes and over 1,000 for Harvard-valued and CMS/Other source codes. CMS is proposing a work RVU of 0.20 for CY 2019. No direct PE refinements are proposed.

Breast MRI with Computer-Aided Detection (CPT® codes 77X49, 77X50, 77X51, and 77X52)

Through the screen tool CMS identified codes 77058 and 77059 (MRI of breast unilateral and bilateral, with and/or without contrast) as high expenditure with more than \$10 million of allowed Medicare charges. When preparing to review the codes, CMS noted the clinical indications had changed for the two MRI scans. Technology has advanced such that computer-aided detection (CAD) is typical and the codes did not closely resemble the structure of other MRI codes. As a result, the June 2017 CPT® Editorial Panel deleted the codes 0159T, 77058 and 77059 and have in place created four new codes for breast MRI for CY 2019.

CMS did not agree with the RUC recommendations of the work RVU for the new codes. CMS believes the values recommended by the RUC are too high and not supported. CMS proposed new values which correspond to similarly valued codes. The new codes for CY 2019 are defined as follows; the full code number will be released by the AMA:

- 77X49 (Magnetic resonance imaging, breast, without contrast material; unilateral)
- 77X50 (Magnetic resonance imaging, breast, without contrast material; bilateral)
- 77X51 (Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD-real time lesion detection, characterization and pharmacokinetic analysis)
- 77X52 (Magnetic resonance imaging, breast, without and with contrast material(s), including computer-aided detection (CAD-real time lesion detection, characterization and pharmacokinetic analysis) when performed; bilateral)

The RUC recommended direct PE input values for the new breast MRI codes were higher than current MRI codes for lower extremities, which CMS used for comparison as the codes were recently reviewed, and the soon-to-be deleted codes. The PE direct inputs for these codes were lower than the proposed values and CMS does not believe the new codes incur more clinical labor time and is proposing new values.



CMS is seeking submission of invoices for three different equipment items as no invoices were received for five items used for direct pricing information in determining value. CMS is proposing to crosswalk to similar equipment items as proxies until there is pricing information provided. The three equipment items in which invoices are requested:

- CAD software (ED058) is crosswalked to flow cytometry analytics software (EQ380)
- Breast coil (EQ388) is crosswalked to Breast biopsy device (coil) (EQ371)
- CAD Workstation (CPU + Color Monitor) (ED056) is crosswalked to Professional PACS workstation (ED053)

The other two items, CAD Server (ED057) and CAD Software – Additional User License (ED059), CMS is not proposing to establish a price at this time as CMS believes they both are forms of indirect PE. CMS is also proposing to refine the direct PE inputs of equipment time for the basic radiology room in accordance with the standard time equipment time formulas.

The following table lists the already established CPT® codes (no new codes are not listed in the table) and the global CY 2018 final work and PE RVUs compared to the proposed changes for global CY 2019 by CMS. Even though the conversion factor is proposed to increase overall for healthcare, due to the proposed RVU changes addressed above, some of the reimbursements related to radiology are proposed to decrease for CY 2019, while others are proposed to increase.

Service Description		WORK RVU			NON-FAC PE RVU		
HCPCS	DESCRIPTION	2018 Final	2019 Proposed	Diff	2018 Final	2019 Proposed	Diff
10021	Fna w/o image	1.27	1.03	(0.24)	2.03	1.54	(0.49)
36568	Insert picc cath	1.67	2.11	0.44	4.38	NA	0.00
36569	Insert picc cath	1.7	1.9	0.20	5.18	NA	0.00
36584	Replace picc cath	1.2	1.2	0.00	4.52	8.59	4.07
38792	Ra tracer id of sentinel node	0.52	0.65	0.13	NA	1.64	0.00
52334	Create passage to kidney	4.82	3.37	(1.45)	NA	NA	0.00
72020	X-ray exam of spine 1 view	0.15	0.23	0.08	0.46	0.54	0.08
72040	X-ray exam neck spine 2-3 vw	0.22	0.23	0.01	0.7	0.8	0.10
72050	X-ray exam neck spine 4/5vws	0.31	0.23	(0.08)	0.94	1.12	0.18
72052	X-ray exam neck spine 6/>vws	0.36	0.23	(0.13)	1.19	1.39	0.20
72070	X-ray exam thorac spine 2vws	0.22	0.23	0.01	0.72	0.75	0.03
72074	X-ray exam thorac spine4/>vw	0.22	0.23	0.01	0.86	0.92	0.06
72080	X-ray exam thoracolmb 2/> vw	0.22	0.23	0.01	0.71	0.72	0.01
72100	X-ray exam l-s spine 2/3 vws	0.22	0.23	0.01	0.75	0.82	0.07
72110	X-ray exam l-2 spine 4/>vws	0.31	0.23	(0.08)	1.04	1.14	0.10
72114	X-ray exam l-s spine bending	0.32	0.23	(0.09)	1.39	1.32	(0.07)
72120	X-ray bend only l-s spine	0.22	0.23	0.01	0.91	1.02	0.11
72200	X-ray exam si joints	0.17	0.23	0.06	0.61	0.72	0.11

72202	X-ray exam si joints 3/> vws	0.19	0.23	0.04	0.72	0.8	0.08
72220	X-ray exam sacrum tailbone	0.17	0.23	0.06	0.61	0.72	0.11
73070	X-ray exam of elbow	0.15	0.23	0.08	0.6	0.63	0.03
73080	X-ray exam of elbow	0.17	0.23	0.06	0.7	0.68	(0.02)
73090	X-ray exam of forearm	0.16	0.23	0.07	0.55	0.66	0.11
73650	X-ray exam of heel	0.16	0.23	0.07	0.59	0.61	0.02
73660	X-ray exam of toe(s)	0.13	0.23	0.10	0.65	0.75	0.10
74210	Contrst x-ray exam of throat	0.36	0.59	0.23	1.81	1.92	0.11
74220	Contrast x-ray esophagus	0.46	0.67	0.21	2	2.06	0.06
74230	Cine/vid x-ray throat/esoph	0.53	0.53	0.00	3.08	3.07	(0.01)
74420	Contrst x-ray urinary tract	0	0.52	0.52	0	1.44	1.44
74485	X-ray guide gu dilation	0.54	0.83	0.29	2.05	2.13	0.08
76000	Fluoroscopy <1 hr phys/qhp	0.17	0.3	0.13	1.15	0.99	(0.16)
76870	Us exam scrotum	0.64	0.64	0.00	1.24	2.13	0.89
76942	Echo guide for biopsy	0.67	0.67	0.00	0.99	0.9	(0.09)
77002	Needle localization by xray	0.54	0.54	0.00	2.08	2.29	0.21
77012	Ct scan for needle biopsy	1.16	1.5	0.34	2.29	2.71	0.42
77021	Mr guidance for needle place	1.5	1.5	0.00	9.47	11.85	2.38
77081	Dxa bone density/peripheral	0.22	0.2	(0.02)	0.56	0.74	0.18

Low Volume Codes

CMS generally uses an average of the three most recent years of available Medicare claims data to determine the specialty mix assigned to each code when creating the indirect PE allocators. Codes which have a low volume reporting have to be reviewed differently as there could be some anomaly and this could significantly impact the specialty mix assignment for the RVUs.

In the CY 2018 final ruling CMS finalized the use of the most recent year of claims data to determine which codes are low volume, which are fewer than 100 allowed services in the Medicare claims data. Rather than apply the specialty mix per the specialties of the practitioners billing for the services on the claim forms, CMS would instead use the expected specialty based on medical review and input from expert stakeholders. CMS also finalized to apply the service-level overrides to both the PE and MP RVUs, rather than one or the other.

For CY 2019, CMS is proposing to add 28 codes that have been identified to the low volume services list and the assigned an expected specialty. For each of the codes CMS would only assign a national value to the professional only service (reported with 26 modifier) and the technical and global components would have RVUs and pricing per the Medicare Administrative Contractors (MACs).

The following table outlines the low volume codes proposed to be added to the list. Only those related to diagnostic radiology are listed here.



TABLE 1: New Additions to Expected Specialty List for Low Volume Services

CPT Code	Mod	Short Descriptor	Expected Specialty	2017 Utilization
70557	26	Mri brain w/o dye	Diagnostic Radiology	126
70558	26	Mri brain w/dye	Diagnostic Radiology	32
74301	26	X-rays at surgery add-on	Diagnostic Radiology	73
74355	26	X-ray guide intestinal tube	Diagnostic Radiology	11
74742	26	X-ray fallopian tube	Diagnostic Radiology	5
74775	26	X-ray exam of perineum	Diagnostic Radiology	80
75801	26	Lymph vessel x-ray arm/leg	Diagnostic Radiology	114
75803	26	Lymph vessel x-ray arms/leg	Diagnostic Radiology	41
75805	26	Lymph vessel x-ray trunk	Diagnostic Radiology	50
75810	26	Vein x-ray spleen/liver	Diagnostic Radiology	46
78282	26	Gi protein loss exam	Diagnostic Radiology	8
79300	26	Nuclr rx interstit colloid	Diagnostic Radiology	2

Radiologist Assistant

The minimum level of supervision for diagnostic x-ray and other diagnostic tests is general supervision; however, there are some services which require direct or personal supervision per regulations. Supervision levels are published by CMS on the PFS Relative Value File and for diagnostic imaging procedures, only apply to the technical component of the procedure.

Comments were received for the CY 2018 MPFS proposed ruling recommending supervision requirements for those services typically furnished by a radiologist assistant (RA) under the supervision of a physician be revised. An RA includes those that are either a registered radiologist assistant (RRA), certified by The American Registry of Radiologic Technologists or a radiology practitioner assistant (RPA), certified by the Certification Board for Radiology Practitioner Assistants. Specifically the commenters' recommendations indicated all diagnostic tests, when performed by RAs, should be allowed to be performed under direct supervision rather than personal supervision. Commenters also stated the requirements of the supervision guidelines for some diagnostic tests were restricting to RAs and conflicted with current state laws which allow for RAs to perform these tests. Currently there are 28 states which have statutes or regulations that recognize RAs and the supervision guidelines in these states of the RA-performed services are general or direct supervision.

After consideration of the comments received CMS is proposing to revise the regulations to specify *“at §410.32 to add a new paragraph (b)(4) to state that diagnostic tests performed by an RRA or an RPA require only a direct level of physician supervision, when permitted by state law and state scope of practice regulations. We note that for diagnostic imaging tests requiring a general level of physician supervision, this proposal would not change the level of physician supervision to direct supervision. Otherwise, the diagnostic imaging tests must be performed as specified elsewhere under §410.32(b).”*



Evaluation and Management (E/M) Guidelines

According to CMS E/M visits account for approximately 40% of the allowed charges for MPFS services and 20% are office/outpatient E/M visits. This accounts for a high expenditure by CMS for services to beneficiaries. In CY 2018 rulemaking, CMS requested feedback and comments on how to best update and change evaluation and management (E/M) guidelines. Stakeholders have long commented on the need for change due to the outdated and administratively burdensome guidelines. CMS agreed and in the CY 2018 proposed rules indicated the history and physical exam were the most outdated of the guidelines given current clinical practices, technology advances and the use of EHRs in the documentation process. CMS requested feedback from stakeholders on how best to approach the changes and what changes to make, admitting this would be a multi-year process.

In the CY 2019 proposed rules, CMS has taken on the task of revamping and updating reporting and reimbursement of outpatient E/M services for new and established patient visits. The changes proposed only apply to CPT® codes 99201-99205 and 99211-99215. CMS admitted a step-wise approach was needed and would limit changes now to only the office/outpatient E/M code set. The other code sets for inpatient and emergency department care come with “*unique clinical and legal issues and the potential intersection with hospital Conditions of Participation (CoPs).*” CMS is not ruling out changes or expanding into these areas in the future, but for now are limiting changes to the outpatient codes.

CMS is proposing several changes that will have an impact on providers who perform evaluation and management services with patients. The proposed changes are as follows:

Lifting Restrictions Related to E/M Documentation

Currently there are restrictions in which billing same-day visits by practitioners of the same group and specialty are not separately reimbursable. As outlined in Chapter 12 of the Medicare Claims Processing Manual, Medicare Administrative Contractors MACs may not pay for two E/M office visits billed by a physician for same beneficiary unless documentation supports the visits are unrelated. The intention was that if the patient is seen in multiple visits with same practitioner or special group, each additional E/M would not be medically necessary. As practitioners continue to cross train into multiple specialties it is possible a patient could be seen for different reasons by same physician or specialty group. CMS does not know what financial impact this will have, but believe given current already established practices to space things out, it would not be significant. CMS is seeking comments about eliminating this provision or making adjustments and exceptions.

Providing Choices in Documentation – Medical Decision-Making, Time or Current Framework

Based on comments and feedback, CMS is proposing choices with regard to E/M documentation. The choices would be, continue to utilize the 1995 or 1997 guidelines, utilize a framework designed around the medical decision making (MDM) as the main component or a time based framework. This proposed change would allow practitioners to better select the type of documentation based on the type of visits performed. For some practitioners time based would

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better serve to support the type of work and visits provided to patients. Others practitioners that are comfortable with the 1995 or 1997 guidelines would be able to continue this approach to documenting the E/M visits for outpatients.

By adjusting the documentation practices CMS believes this would lessen the burden to practitioners to no longer document components which are irrelevant to the visit or burdensome to include. The changes would also assist CMS in the forward progress of continued changes to not have to create another set of standardized guidelines as happened in 1995 and 1997. Regardless of which method a practitioner selects to document the E/M visit, CMS would apply the same proposed new reimbursement values to outpatient services.

The current CPT® codes (99201-99215) will still be reported on the claim form by the practitioner to reflect the level of visit the practitioner believes was provided to the beneficiary, regardless of the type of documentation framework selected. This will allow for consistency to current practices in code reporting and to allow for consistency when billing to non-Medicare payers, as there is no clear understanding how commercial payers will react to these proposed changes.

CMS will use the code reported to apply the appropriate reimbursement from one of two proposed levels. CMS is proposing to reimburse the level 1 codes of 99201 and 99211 at a separately designated rate and levels 2-5 (99202-99205 and 99212-99215) would be reimbursed the same amount for all four levels of new patient visits and all four levels of established patient visits. As part of this CMS is proposing a minimum level of documentation, if the practitioner selects to continue using the already established guidelines of 1995 or 1997 requirements, then at least the level 2 must be met.

CMS offered the following examples per the different possible options:

1. Practitioners selecting to continue following current framework of 1995 or 1997 guidelines the proposed minimum documentation for levels 2-5 would be:
 - A problem-focused history that does not include a review of systems or a past, family, or social history;
 - A limited examination of the affected body area or organ system; and
 - Straightforward medical decision making measured by minimal problems, data review, and risk (two of these three).
2. Practitioners selecting the framework of MDM alone would be required to provide the following minimum documentation:
 - Straightforward medical decision-making measured by minimal problems, data review, and risk (two of these three).
 - CMS is proposing the MDM documentation requirements would follow the current guidelines but are seeking comments on how to change in subsequent years.
3. Practitioners selecting the framework of time or duration of visit would be required to provide the following minimum documentation:



- A statement of medical necessity for the visit and document the amount of time personally spent by the billing practitioner face-to-face with the patient.
- CMS is seeking comments on the typical time expected per the newly proposed payment system for outpatient E/M visits.
 - CMS used 38 minutes as the average for a new patient visit and 31 minutes for an established patient visit when setting up the proposed payment values.

In an effort to continue to ease the burden of documentation from practitioners, CMS is also proposing for the key components of history and exam for established patients, and only those corresponding items which had changed or have not changed since the last visit would be documented. This would replace the need to document all of the components as outlined in the current guidelines. Practitioners would still be expected to conduct medically necessary inquiries and exams of the patient in order to support the visit and gather the necessary information; however, if there is documentation to support the repetitive components have been reviewed elsewhere the components would not need to be repeated. CMS is seeking comments on how to apply this similar logic to new patients when the available data is accessed through a shared EHR or some other data exchange.

Regardless of which framework is selected, CMS is proposing two different reimbursement values between the 5 levels of new patient visits and two different reimbursement values between the 5 levels of established patient visits.

Tables 19 and 20 reflect the current CY 2018 Medicare National Rates for the outpatient E/M visit codes and the proposed rates of lumping all level 2-5 E/M visit codes into the same RVU and payment category for the respective type of visit.

*Note in Table 19, the CY 2018 Non-facility Payment Rate under the proposed Methodology column header by CMS appears to be the wrong date, these are in fact CY 2019 rates.



TABLE 19: Preliminary Comparison of Payment Rates for Office Visits New Patients

HCPCS Code	CY 2018 Non-facility Payment Rate	CY 2018 Non-facility Payment Rate under the proposed Methodology
99201	\$45	\$44
99202	\$76	\$135
99203	\$110	
99204	\$167	
99205	\$211	

TABLE 20: Preliminary Comparison of Payment Rates for Office Visits Established Patients

HCPCS Code	Current Non-facility Payment Rate	Proposed Non-facility Payment Rate
99211	\$22	\$24
99212	\$45	\$93
99213	\$74	
99214	\$109	
99215	\$148	

Due to the significant changes proposed and the impact that some specialties may experience, CMS is proposing additional measures to better capture the resource costs and offset the impact.

- *An E/M multiple procedure payment adjustment to account for duplicative resource costs when E/M visits and procedures with global periods are furnished together;*
- *HCPCS G-code add-ons to recognize additional relative resources for primary care visits and inherent visit complexity that require additional work beyond that which is accounted for in the single payment rates for new and established patient levels 2 through level 5 visits;*
- *HCPCS G-codes to describe podiatric E/M visits; (not addressed in this summary)*
- *An additional prolonged face-to-face services add-on G code; and*
- *A technical modification to the PE methodology to stabilize the allocation of indirect PE for visit services*

CMS is proposing when multiple services are performed on the same date of service, a E/M and some other procedure, a reduction of 50% of the established rate will be applied to the lesser



reimbursed code. This is similar logic to the current multiple procedure payment reduction (MPPR) policy. The MPPR is applied when multiple procedures, such as surgical procedures, are performed on the same beneficiary on same date of service. The highest level code is reimbursed at the full amount and the next one is paid at 50% of the established rate. For CY 2019, CMS is proposing to apply a reduction of 50% to the lesser reimbursed code when the practitioner furnishes a new or established patient visit on the same date as another procedure and the 25 modifier is applied to the E/M.

CMS is proposing two HCPCS G-codes to essentially make-up for the extra resources experienced by some specialties. Neither of these options will apply directly to radiology. The G-code proposed for primary care will not be summarized here.

CMS is proposing a new add-on G-code GCG0X (Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit). CMS believes these specialties apply predominantly nonprocedural services for complex conditions that impact multi-organ and neurologic diseases. Additionally, these specialties would be the most impacted by the creation of one reimbursement rate for E/M levels 2-5. The add-on code GCG0X would be billed in addition to the E/M code by the specialties outlined. The proposed Medicare national rate is \$13.70 both facility and non-facility based.

CMS is concerned given the sweeping changes to E/M visits and combining four levels into one, accounting for some of the practice expense (PE), direct and indirect, cannot be accurately attributed to the specialties. This is due to the uncertainty of not being able to fully predict which specialties will utilize the simplified E/M codes and proposed G-codes and how current indirect practice expense values are calculated. CMS is proposing to create a single PE/HR (hour) for E/M visits and proposed G-codes. If this is finalized it may be reviewed again after several years of available claims data.

Currently there are CPT® codes (99354 and 99355) to account for prolonged services. The minimum time to meet the threshold in order to bill 99354 is one hour. Many stakeholders commented it is difficult to meet this threshold and is an impediment to many specialties in reporting the codes. Given the proposed changes to levels 2-5, CMS is proposing to create a new 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 (List separately in addition to code for office or other outpatient Evaluation and Management or psychotherapy service) to represent prolonged E/Ms. The Medicare CY 2019 national average proposed payment rate is \$67.41 non-facility based and \$63.08 facility based.

When reviewing the impact of the coding, it is important to note that some specialties could bill for multiple add-on codes in addition to the E/M visit code. The following tables reflect the



anticipated impact of a few specialties. Table 21 reflects the potential impact to specialties **without** the added G-codes or additional adjustments. Table 22 reflects the potential impact to specialties **with** the added G-codes or additional adjustments.

TABLE 21: Unadjusted Estimated Specialty Impacts of Proposed Single RVU Amounts for Office/Outpatient E/M 2 through 5 Levels

Specialty	Allowed Charges (mil)	Estimated Potential Impact of Valuing Levels 2-5 Together, Without Additional Adjustments
Physician Assistant	\$2,253	Less than 3% estimated increase in overall payment
Radiation Oncology and Radiation Therapy Centers	\$1,776	
Radiology	\$4,898	

TABLE 22: Specialty Specific Impacts Including Payment Accuracy Adjustments

Specialty	Allowed Charges (mil)	Estimated Potential Impact of Valuing Levels 2-5 Together, With Additional Adjustments
Physician Assistant	\$2,253	Less than 3% estimated increase in overall payment
Radiology	\$4,898	Minimal change to overall payment
Radiation Oncology and Radiation Therapy Centers	\$1,776	Less than 3% estimated decrease in overall payment

*CMS assumes hematology/oncology utilized the G-code for visit complexity with every E/M office/outpatient visit code.

Finally regarding proposed E/M changes, CMS is proposing to adjust teaching physician documentation requirements. To eliminate duplicative efforts and notations in the medical record CMS is proposing to simplify teaching physician E/M service documentation requirements.

CMS is proposing to “amend §415.172(b) to provide that, except for services furnished as set forth in §§415.174 (concerning an exception for services furnished in hospital outpatient and certain other ambulatory settings), 415.176 (concerning renal dialysis services), and 415.184 (concerning psychiatric services), the medical records must document that the teaching physician was present at the time the service is furnished.” The revised paragraph would indicate the presence of the teaching physician during procedures and E/M service may be documented with a note in the medical record made by a physician, resident or nurse.

CMS is also proposing to delete the requirement the teaching physician document the extent of the participation in the review and direction of services. A new paragraph would be added to the guidelines to require the teaching physician to document the extent of the participation and



direction of services provided to the beneficiary. The extent of the participation can be demonstrated by notes in the medical records by a physician, resident or nurse.

The proposed changes for E/M coding and reimbursement are significant. To succinctly summarize the proposed changes that were reviewed above, here are the bullet point takeaways:

- Physicians would be able to select from one of three different means for documenting E/Ms
 - Current 1995 or 1997 guidelines, MDM or time based
- CMS would have 2 levels of reimbursement
 - Level 1 codes, 99201 and 99211 would each have a set rate
 - Level 2-5 codes, 99202-99205 and 99212-99215 would have one set rate per group of codes, all codes in the group regardless of level valued the same
- Certain specialties would have additional G-codes as add-on codes to reflect the extra work and values lost by the proposed changes.
- Prolonged service HCPCS code GPRO1 would be billable to account for prolonged E/M services by all specialties.
- CMS is proposing to remove duplicative documentation requirements for E/Ms. One proposed change impacts teaching physicians. Teaching physicians would be able to document the extent of participation and services provided in a note.

Proposed Payment Rates for Nonexcepted Off-Campus Provider-Based Departments

The Bipartisan Budget Act of 2015 established new guidelines to address the difference in reimbursement payments for the exact same procedure between varying places of service, primarily hospital vs. ambulatory surgical center (ASC) vs. physician office. The Act established a hard and fast deadline (November 2, 2015) for establishment of any new provider-based departments and the distance (250 yards) the new department could be from the main building of the hospital and still receive payment rates established under the Hospital Outpatient Prospective Payment System (HOPPS). Due to what was considered an alarming rate of hospitals acquiring physician practices and the tendency for provider-based departments of a hospital to be paid more than a traditional office setting, changes were made.

CMS is proposing for CY 2019 to maintain the CY 2018 PFS Relativity Adjuster (reimbursement) for nonexcepted off-campus provider-based departments (first billed services were dated on or after November 2, 2015 and more than 250 yards from main building of hospital) of 40% of the HOPPS rate for the same service for next year and beyond. Per CMS, *“Moreover, we propose to maintain this PFS Relativity Adjuster for future years until updated data or other considerations indicate that an alternative adjuster or a change to our approach is warranted, which we would then propose through notice and comment rulemaking.”*

Additionally, nonexcepted off-campus provider-based departments will continue to bill for services on the UB04 claim form, apply the “PN” modifier to services and are still subject to the hospital supervision rules and other practice guidelines. Radiation oncology departments will continue to bill for daily treatments and image guidance in the nonexcepted off-campus provider-based departments (PBD) setting using the G-codes created by CMS, and currently used by



freestanding facilities, with the “PN” modifier applied to each billing through the end of CY 2019 as mandated by law. The G-codes for daily treatment (G6003 – G6015) and image guidance (G6001, G6002, G6017 and 77014) are not paid or proposed to be paid at 40% of the HOPPS rate, but at the technical rate under MPFS in the nonexcepted setting. Hospital on-campus departments and excepted off-campus PBDs continue to bill the CPT® codes for daily treatment (77402, 77407, 77412, 77385 and 77386) and image guidance code 77387 where appropriate.

Excepted off-campus PBDs, those settings which were established and billing for services prior to November 2, 2015 and within the previously set distance of 35 miles, are not impacted by the PFS Relativity Adjuster. Excepted off-campus PBDs will continue to be paid at the HOPPS full established rate for each service and accounting for all packaging and bundling.

Appropriate Use Criteria for Advanced Diagnostic Imaging Services

The appropriate use criteria (AUC) program was mandated as part of the Protecting Access to Medicare Act (PAMA) and MACRA and outlined that CMS must establish a program to promote appropriate use criteria for advanced diagnostic services. This program will impact medical oncologists who may be ordering advanced diagnostic imaging services (CT, MRI, nuclear medicine (including PET) and US) for any patients under their care.

The AUC program will begin January 1, 2020 and CMS is not proposing any change to this date which was finalized in the CY 2018 final rule. This AUC program requires any physician ordering advanced diagnostic imaging services consult a Clinical Decision Support Mechanism (CDSM) of the AUC and the interpreting physician and facility where the study is performed must then report the results on their respective Medicare claims.

The CDSM is the electronic portal the ordering physician uses to access the AUC. The CDSM can be a standalone application which requires direct entry of the patient information into the portal; however, the most effective method would be to access directly through the Electronic Health Record (EHR). CMS released a list of qualified CDSMs in June 2018, for ordering physicians to review and become acquainted with. The list can be found at.

CMS is proposing to add an additional site to the list of applicable settings where the AUC is utilized. The Act outlined the applicable settings as a physician’s office, a hospital outpatient department (including an emergency department), an ASC and any other provider-led outpatient setting determined appropriate by the Secretary. CMS is proposing to add independent diagnostic testing facility (IDTF) to the list of applicable settings. The services provided in an IDTF require physician supervision and written orders must be furnished. CMS believes this means the IDTF is a provider-led outpatient setting and appropriate to be added to the list. Additionally, CMS believes by adding IDTFs to the list this will ensure the AUC program is in place across outpatient settings where advanced diagnostic imaging is provided.

The furnishing physician and imaging facility must both report the specific coding information for the advanced imaging service billed on each claim form. Reporting for the AUC is not solely on the physician claim form, the facility portion must also represent the information on that claim as



well. CMS is proposing to develop a series of G-codes and modifiers to report the required AUC information. After considerable feedback and scenarios presented in which just G-codes or just modifiers might not be the best solution, CMS is proposing to incorporate both to ensure the program is implemented by January 1, 2020. It is still unclear how some of the code and modifier combinations will be applied for the many various scenarios, the test year may highlight how well the implementation addresses all of the concerns. Each claim will be required to document the following three items for each billed service:

- Which qualified CDSM was consulted by the ordering professional;
- Whether the service ordered adhered to specified applicable AUC, did not adhere to specified applicable AUC, or whether specified applicable AUC were not applicable to the service ordered;
- The NPI of the ordering professional (if different from the furnishing professional)

After considerable requests for clarification by stakeholders on who can access the CDSM for any advanced diagnostic imaging, CMS is proposing the consultation may be performed by auxiliary personnel incident to the ordering physician or non-physician practitioner's professional service. This would allow the ordering professional to delegate to the appropriate personnel the work in accessing the use of the AUC. The ordering professional is still responsible for the consultation as it is the NPI of the ordering physician reported on the furnishing professional claim form. Additionally, it is the ordering professional that would be identified as an outlier and subjected to prior authorization requirements based on ordering patterns.

CMS is also asking for comments on how to best measure or the methodology for determining outlier ordering professionals. Specifically which data elements and thresholds to use to identify the ordering outliers. Claims data from the testing period of July 1, 2018 – December 31, 2019 will not be used to identify any ordering outliers, instead CMS will use data beginning January 1, 2020. This means identifying the ordering outliers will be more fully addressed in the rulemaking for CY 2022 or 2023.

Even though the program does not officially begin until January 1, 2020 the testing period is currently in effect through December 31, 2019. The initial list of outlier ordering professionals established in CY 2017 MPFS final rule is not proposed to change. This list of outliers impacts providers ordering advanced diagnostic imaging services for the following:

- Coronary artery disease (suspected or diagnosed)
- Suspected pulmonary embolism
- Headache (traumatic and non-traumatic)
- Hip pain
- Low back pain
- Shoulder pain (to include suspected rotator cuff injury)
- Cancer of the lung (primary or metastatic, suspected or diagnosed)
- Cervical or neck pain



CMS is also proposing to adjust the significant hardship exception requirements under the AUC program. CMS proposed that any ordering professional experiencing any of the following would not be required to consult the AUC using a qualified CDSM and the claim would not be required to list the AUC consultation information.

- Insufficient internet access;
- EHR or CDSM vendor issues; or
- Extreme and uncontrollable circumstances

CMS is proposing the ordering professional would self-attest if there is significant hardship at the time of placing an advanced diagnostic imaging order. The attestation would be supported with documentation and this information would be communicated with the AUC consultation information to the furnishing professional with the order. The claim submitted by the rendering professional and facility would report the necessary HCPCS modifier to reflect the hardship self-attestation. The rendered claim would not be required to include the AUC consultation information. CMS is requesting comments regarding circumstances which could be considered significant hardships, posing particular real-time difficulty or challenge to the ordering professional in consulting AUC.

Submitting Comments

Comments to CMS regarding the MPFS proposed rule must refer to file code **CMS-1693-P** and be received **no later than 5 pm EST September 10, 2018**. Electronic submission is encouraged by CMS, <http://www.regulations.gov>. Follow the instructions and