Member Alert

New CMS Proposed Rule Could Impact GI Practice

Late Thursday, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2019 Medicare Physician Fee Schedule (PFS) proposed rule, which includes several significant policy and payment changes that will impact gastroenterologists. This year, the PFS proposed rule also includes changes to year three of the Quality Payment Program (QPP).

This communication offers a topline summary of the most important proposed changes to the payment rates and policies for services paid under the Medicare PFS. The PFS proposed rule will appear in the *Federal Register* on July 17 th and can be downloaded **here** .

Key proposals:

- Major evaluation and management (E/M) changes aimed at reducing physician burden impact coding and reimbursement.
- EGD and colonoscopy codes identified by an outside party as potentially misvalued.
- Weight of the cost performance category under QPP increases from 10% to 15%.
- CMS proposes adding a GI-specific cost measure for screening/surveillance colonoscopy.
- QPP performance threshold increases from 15 points to 30 points.

ACG, AGA and ASGE are currently reviewing the details of the proposed rules and will be providing joint comments.

CMS will accept comments until September 10, 2018, and will respond to comments in a final rule to be issued on or around November 1, 2018. We will keep you updated as we learn more.

Medicare Physician Payment

- **2019 Proposed Conversion Factor:** The proposed 2019 PFS conversion factor is $36.05, an increase of .03 percent from the 2018 PFS conversion factor of $35.99. **Click here** to review 2019 MPFS proposed Relative Value Units (RVUs) for GI services.

- **Reforming Evaluation and Management (E/M) Payment:** CMS proposes a major new reimbursement methodology for E/M services effective January 1, 2019. Under the proposal, new patient level 2-5 (99202-99205) and established patient level 2-5 (99212-99215) services would receive one blended payment.

The table below reflects the proposed rates.

CPT	2018 Final Work RVUs	2019 Proposed Work RVUs	2018 Final Non-Facility Payment	2019 Proposed Non-Facility Payment
New Patient Office Visit				
99201	0.48	0.48	$45	$44
99202	0.93	1.90	$76	$135
99203	1.42	1.90	$110	$135
99204	2.43	1.90	$167	$135
99205	3.17	1.90	$211	$135
Established Patient Office Visit				
99211	0.18	0.18	$22	$24
99212	0.48	1.22	$45	$93
99213	0.97	1.22	$74	$93
99214	1.5	1.22	$109	$93
99215	2.11	1.22	$148	$93

** Note: despite some discrepancy in calculations, these tables were taken directly from the proposed rule.*

CMS proposes changing how physicians document office/outpatient E/M visits instead of applying the current 1995 or 1997 E/M documentation guidelines. Proposed changes include allowing practitioners to:

- Use time as the governing factor in selecting visit level and documenting the E/M visit, regardless of whether counseling or care coordination dominate the visit.
- Focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information.
- Simply review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.

The agency is soliciting comment on how documentation guidelines for medical

decision-making might be changed in future years.

Finally, CMS is proposing several new G codes as E/M add-on services for primary care services, specialty professionals and prolonged services.

- **Misvalued Code Initiative**: CMS received a public nomination of several high-volume codes to be reviewed under the potentially misvalued code initiative, including two GI services: 45385 (Colonoscopy with lesion removal) and 43239 (EGD biopsy single/multiple). The submitter suggested that the services identified have a systemic overvaluation of work RVUs. The societies will work in a unified manner to be certain that the GI codes identified are indeed properly valued.

Public Nominations Due to Overvaluation	
CPT Code	**Short Description**
27130	Total hip arthroplasty
27447	Total knee arthroplasty
43239	EGD biopsy single/multiple
45385	Colonoscopy w/lesion removal
70450	CT head w/o contrast
93000	Electrocardiogram complete
93306	TTE w/Doppler complete

- **Communication Technology-Based Services:** CMS proposes allowing communication technology-based services to be billable separately for brief communication services when providers check in with beneficiaries via telephone or other telecommunication devices or receive images from patients for remote evaluation to determine whether an office visit or other service is needed. CMS proposes 0.25 work RVUs for these services using HCPCS code GVCI1.

  CMS also proposes paying separately for new codes describing Interprofessional Internet Consultation. Communication Technology Based Services would not be subject to the limitations on Medicare telehealth services.

- **Wholesale Acquisition Cost-Based Payment for Part B Drugs:** CMS proposes reducing the add-on amount for Part B drug payments based on Wholesale Acquisition Cost to 3% effective January 1, 2019.

Quality Payment Program

The PFS proposed rule includes changes to the QPP, including the Merit-based Incentive Payment System (MIPS). The table and information below summarize key proposed changes for the 2019 MIPS performance period and the 2021 payment period.

	2018 Final	**2019 Proposed**
Performance Threshold	15 points	30 points
Quality	50 percent	45 percent
Cost	10 percent	15 percent
Improvement Activites	15 percent	15 percent
Advancing Care/Promoting Interoperability	25 percent	25 percent
MIPS Payment adjustment	+/- 5 percent	+/- 7 percent

- **MIPS Payment Adjustments**: To avoid a negative payment adjustment, clinicians must have a final MIPS score equal to or greater than the performance threshold. The maximum payment adjustments for performance in year 2019 is +/- 7 percent and would apply to payments in 2021.

- **Quality Category:** CMS proposes removing 34 quality measures, including QPP185 (Colonoscopy Interval for Patients with a History of Adenomatous Polyps – Avoidance of Inappropriate Use).

- **Cost Category:** CMS proposes adding a new cost measure for screening/surveillance colonoscopy to the performance category beginning with the 2019 MIPS performance period.

- **Improvement Activities:** CMS proposes adding six new improvement activities.

- **Promoting Interoperability:** CMS renamed the "Advancing Care Information" performance category "Promoting Interoperability." Proposed 2019 changes include:
    - Reporting a total of six measures from four objectives.
    - Use of EHR technology certified to the 2015 Edition.
    - Simplifying scoring methodology; concept of Base and Performance scores eliminated.

  CMS proposes continuing the "all or nothing approach" for this performance category. If a MIPS-eligible clinician fails to report on a required measure or reports a "no" response on a "yes or no" measure, the clinician would receive a score of zero for the category (unless an exclusion applies).

- **Small Practices:** CMS proposes additional policies to increase flexibilities for small practices, including allowing small practices, whether reporting as individual clinicians or as a group, to use a claims-based measure submission option. CMS does, however, propose eliminating the 5-point bonus applied to a small practice's total performance score. Instead, CMS proposes to apply a 3-point bonus to the Quality performance category for small practices.

- **Alternative Payment Models:** CMS proposes increasing the Advanced APM Certified Electronic Health Record Technology (CEHRT) threshold, so that an Advanced APM must require that at least 75% of eligible clinicians in each APM entity use CEHRT and allows eligible clinicians to become qualified participants through a combination of participation in Advanced APMs and other payer Advanced APMs.

Thank you for your time. Please contact your GI Society with any questions:

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ACG, AGA and ASGE are committed to collaborate on issues of common interest to all members of the GI community, including public policy and regulatory challenges facing gastroenterologists. This message is being sent as a joint communication from the three societies and has been reviewed by each organization.
For more information: ACG website – AGA website – ASGE website

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