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CMS Issues Proposed Rule with Significant Revisions to the Medicare Physician Fee Schedule and Other Payment Policies

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On July 12, 2018, the Centers for Medicare & Medicaid Services ("CMS") issued a proposed rule that includes proposals to update payment policies and rates for services furnished under the Medicare Physician Fee Schedule ("PFS") on or after January 1, 2019 (the "Proposed Rule").

Some of the noteworthy provisions included in the Proposed Rule relating to the PFS include:

1. **Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services:** To increase access to communication technology-based physician services, CMS proposes to pay separately for two newly defined services furnished using communication technology. The first, Brief Communication Technology-Based Service, e.g., Virtual Check-In (HCPC code GVC11), would be billable when a physician or other qualified health care professional ("QHCP") has a brief non-face-to-face check-in with a patient via communication technology, to determine whether the patient's condition necessitates an office visit. CMS seeks comments on the types of technology currently utilized by physicians and QHCPs (e.g., audio-only telephone interactions vs. video interactions). The second proposed new service is Remote Evaluation of Pre-Recorded Patient Information (HCPCS Code GRAS1), which would allow practitioners to be paid separately for reviewing patient-transmitted photo or video information to assess whether a visit is needed. CMS also proposes to pay separately for Interprofessional Internet Consultation services (CPT codes 994X6, 994X0, 99446 – 99449), which are conducted through telephone, internet or electronic health record consultations when a patient's treating physician or QHCP requests the opinion and/or treatment advice of a consulting physician or QHCP with specific expertise to assist with the patient without the need for the patient's face-to-face contact with the consulting physician or QHCP.

2. **Telehealth:** CMS seeks to add mobile stroke units, renal dialysis facilities and the homes of ESRD beneficiaries receiving home dialysis to the definition of "originating site." This would allow for Medicare payment of telehealth services for patients located in such settings (so long as all other requirements for Medicare coverage are met).

3. **Supervision of Radiologist Assistants:** Currently, some diagnostic tests require either direct or personal physician supervision. Based on stakeholder comments that the current requirements are too burdensome, CMS proposes to revise the physician supervision requirements so that any diagnostic test performed by a Radiologist Assistant ("RA") may be furnished under, at the most, direct supervision (when performed by the RA in accordance with state law).

4. **Evaluation and Management (E/M) Visits:** CMS proposes to ease requirements related to E/M documentation to provide practitioners with greater flexibility to exercise clinical judgment in documentation and to focus on what is clinically relevant and medically necessary for each beneficiary. Some of the proposals related to E/M visits include the following:

    a. With regard to E/M visits furnished in a patient's home, CMS proposes to eliminate the requirement that the medical record document the medical necessity of a home visit made in lieu of an office or outpatient visit.

    b. CMS seeks public comment on whether to allow coverage for more than one E/M office visit billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day.

    c. For office/outpatient visit codes (CPT codes 99201 through 99215), CMS proposes to allow practitioners to choose, as an alternative to the current framework specified under the 1995 or 1997 guidelines, either Medical Decision-Making or time as a basis to determine the appropriate level of E/M visit.

    d. CMS proposes single blended payment rates for new and established patients for office/outpatient E/M level 2 through 5 visits and a series of add-on codes to reflect resources that are needed beyond which is accounted for in the single payment rates.

5. **Teaching Physician Documentation Requirements for E/M Visits:** Medicare Part B currently makes payment under the PFS for teaching physician services when certain conditions are met. One such condition is that medical record must reflect the teaching physician's participation in the review and direction of services performed by residents in teaching settings. For E/M visits, the teaching physician is required to personally document his/her participation in the medical record. In response to comments, CMS proposes to simplify these documentation requirements by allowing, with a few exceptions, the medical records to show that the teaching physician was present at the time the service was furnished, and such documentation may be made by a physician, resident or nurse. Moreover, the extent of the teaching physician's participation in each patient's care may be documented by a physician, resident or nurse, and no longer needs to be documented personally by the teaching physician.

6. **Therapy Services:** CMS proposes to discontinue the functional status reporting requirements in which all providers of outpatient therapy services, including physical, occupational, and sleep therapy services, have been required to submit a description of a patient's functional limitation and severity at various times throughout the provision of such services.

The Proposed Rule also touched upon other proposed payment policy changes related to the following:

1. **Clinical Laboratory Fee Schedule:** CMS proposes to revise how Medicare determines reimbursement for clinical diagnostic laboratory tests ("CDLTs") under the Clinical Laboratory Fee Schedule ("CLFS"). Since January 1, 2018, the CLFS payment amount for CDLTs has been based on information collected from "applicable laboratories" during specified data collection periods. CMS rates generally are equal to the weighted median of the private payor rates for the applicable test. In revising its formula for payment rate determinations, CMS proposes changing the treatment of Medicare Advantage ("MA") payments in its definition of "applicable laboratory" in order to gain as much relevant information as possible from the national laboratory market. CMS is also seeking public comments on alternative means of defining an "applicable laboratory," but a finalization of the Proposed Rule as-is could allow many more laboratories serving Medicare Part C beneficiaries to qualify as applicable laboratories and, as a result, such laboratories would be required to report their data to CMS. CMS also is contemplating limiting the percentages by which CLFS payment rates for CDLTs can be reduced within a given year. The contemplated limit is 10 percent for the first three years following implementation, and 15 percent in each of the

subsequent three years.

2. **Ambulance Fee Schedule:** CMS proposes a codification of the statutory requirement in the Bipartisan Budget Act of 2018 ("BBA") that certain temporary payment add-ons for ground ambulance services be extended through December 31, 2022. These payment add-ons would apply to covered ground ambulance transports furnished before January 1, 2023. Among these intended add-ons is an increased base rate of 22.6 percent of the fee schedule for ground transports originating in qualifying rural areas and a 2 percent increase in the base and mileage rate for ground ambulance transports that originate in urban areas. The BBA also reduced payments for non-emergency basic life support transports of patients with end-stage renal disease for dialysis services, and CMS proposes to conform its regulations to such BBA provisions.

3. **Medicare Shared Savings Program:** CMS proposes a reduction in the number of measures Accountable Care Organizations ("ACOs") must report, particularly as it relates to patient experiences of care, and CMS Web Interface and claims-based measures. By streamlining its measure set and focusing more on outcome-based measures, CMS hopes to reduce the administrative burden reporting places on ACOs, thereby allowing them to reinvest their resources in greater patient care. CMS further intends to reduce reporting burdens by aligning these changes with the proposed changes to the Merit-based Incentive Payment System ("MIPS") in order to reduce reporting redundancy.

4. **Physician Self-referral Law:** CMS proposes to codify, in statute, its existing policies concerning writing and signature requirements for certain compensation arrangement exceptions to the statute's referral and billing prohibitions. CMS intends to add a special rule at 42 CFR §411.254(e), concerning compensation arrangements, which allows the writing requirement to be satisfied by "a collection of documents, including contemporaneous documents evidencing the course of conduct between the parties involved." As it pertains to certain arrangements involving temporary noncompliance with the signature requirements, CMS proposes to amend 42 CFR §411.353(g) to reflect the recent addition to the "Signature Requirement" section of the BBA, which allows the signature requirement in certain compensation arrangements to be satisfied if the parties obtain the required signatures within 90 days of the date on which the arrangement became noncompliant, provided the arrangement meets all other compliance requirements.

The deadline to submit comments in response to the Proposed Rule is September 10, 2018.