

CMS FINAL RULE FOR 2019

ACOFP Reference Guide

CMS E/M Coding and Payment for 2019

ACOFP and over 150 associations submitted comment letters to CMS regarding the [Physician Fee Schedule \(PFS\)](#) arguing *against* the proposed rule that would have made drastic reductions to the E/M Level 2-5 payments in 2019. AMA and MGMA requested additional time to review the impact of any changes to physician payment and patient care.

With such strong sentiment to this part of the rule, CMS decided to further consider the issue. In short, **CMS delayed any changes or action on E/M coding until 2021.**

The CMS decision does not alter coding or payment in 2019 or 2020. Continue to use E/M codes as in 2018 for CY 2019 and 2020. Reimbursement will remain the same.

Also, CMS is **not finalizing*** its proposal to reduce the payment rate of the lower cost service when an E/M service is furnished on the same day as other procedures (the multiple procedure payment reduction). This is critical for physicians who provide E/M services in addition to OMT.

*CMS chose not to finalize several areas in the final rule. This allows CMS flexibility to finalize certain elements of the rule later, without delaying the timely release of the final rule in its entirety.

E/M Documentation Changes for 2019

These [documentation changes](#) are optional, per CMS, and provide some relief from documentation burden.

- It is no longer a requirement to document the medical necessity of a home visit in lieu of an office visit.
- When relevant information is already in the medical record for established patients, eligible clinicians can focus documentation on what has changed since the last visit or pertinent items that have not changed. If there is evidence that the clinician reviewed the previously documented information, there is no need to document it again.
- There is also no need to document the chief complaint and history for new and established patients if it has already been entered by ancillary staff or the beneficiary, as long as the clinician indicates that he or she reviewed and verified the information.

Consider that insurance companies may require the previous year's, 2018 documentation, to pay a physician's claim.

MIPS Physician Exemptions for 2019

CMS has added additional low-volume threshold exemptions. To be excluded from reporting, providers or groups need to meet at least one of the following conditions:

- Have \$90,000 or less in Medicare Part B allowed charges for covered professional services
- Provide care to 200 or fewer Part B-enrolled patients
- Provide 200 or fewer covered professional services under the PFS
- A physician who is accepting Medicare patients for the first year
- Rural physicians who practice in Health Practice Shortage Areas (HPSA)
- Federally qualified health center (FQHC), rural health clinic (RHC), Ambulatory surgical center (ASC), home health agency (HHA), hospice, or Hospital outpatient department (HOPD) facility payments billed under the facility's all-inclusive payment methodology

Earn Plus 7% on your Medicare Part B Billing

For the [Quality Payment Program in 2019](#), there is a possible positive payment adjustment for Part B payments, to a negative 7% adjustment based on your total score out of 100 points. Additional positive compensation is possible up to 14 percent for high scores.

You need to earn:

- 30 points to avoid a negative payment adjustment
- 75 points or higher to gain a maximum positive payment adjustment
- 0 to 7.5 points gets a maximum negative payment adjustment of 7%

Quality Reporting and Resource Use stay at a 12-month period for reporting, while Improvement Activities and Promoting Interoperability remain at a continuous 90-day period.

For 2019, the breakdown of reporting is the following:

- Quality – 45%
- Costs – 15%
- Practice Improvement Activities – 15%
- Promoting Interoperability (EMR Use) – 25%

Costs are tracked for physicians by CMS using claims. CMS uses three parameters to assess cost:

- Medicare Spending per Beneficiary (MSPB)
- Total Per Capita Costs (TPCC)
- Eight New Episode Based Measures

Practice Improvement and Promoting Interoperability are attestations. **Quality can be tracked through claims data if you are a small practice with 15 or fewer eligible clinicians.** This can be done by selecting six quality measures and using Quality Data Codes (QDC) on your claims. **Use form CMS-1500** and ensure that your billing system is set up to accept QDCs. This will save you significant time during the reporting phase of the QPP.

Clinician Types Required to Report MIPS

Eligible clinicians who are required to report include:

- DO/MD
- NP, CNA, CRNA
- PA
- Psychologist
- Physical Therapist
- Occupational Therapist
- Registered Dietician/Nutrition Professionals
- Audiologist

Physicians in Facility-Based Practice – Reporting Exceptions

If you are a physician who practices in a hospital, on-campus outpatient hospital, or emergency room and 75% or more of your covered professional services are billed there (Point of Service 21, 22, 23), no submission is required for Quality and Cost.

Changes to the ACO and MSSP Reporting Rule

As part of this final rule, CMS also finalized proposals that relate to Accountable Care Organizations (ACOs) and [Medicare Share Savings Programs \(MSSPs\)](#). Specifically, CMS finalized:

- A voluntary 6-month extension for existing ACOs whose participation agreements will expire on December 31, 2018
- A modification to the definition of “primary care services” used to assign beneficiaries to ACOs and to reflect recent code changes
- Relief for ACOs and clinicians impacted by extreme and uncontrollable circumstances during performance year 2018 and subsequent years
- Revisions to further promote interoperability among ACOs and suppliers, including Certified EHR Technology use requirements that align with the QPP

Additional rules are still being finalized by CMS and will be reported to members when they become part of the Final Rule for 2019.

Billing and Payment for Telemedicine Services – CMS Broadens Use

Effective January 1, 2019, CMS finalized two new physician services using telemedicine. These codes include:

- **G2012:** Brief communication technology-based service (e.g., virtual check-in) by a physician or other qualified health care professional who can report E/M services. The payment amount is **\$14.78**.
- **G2010:** Remote evaluation of recorded video and/or images submitted by an established patient. The payment amount is **\$12.61**.

There are some restrictions for using these codes. They can only be used for established patients and cannot lead to an E/M service or procedure within the next 24 hours, or soonest available appointment.

Access the list of [telehealth codes](#) for 2019, which can be used starting January 1, 2019.

Telemedicine rules and payment vary with insurers and states. Please check with these entities for non-Medicare telemedicine use.

ACOFPP is providing a [Telemedicine Podcast](#) for members to learn the details of CMS' telemedicine expansion for urban and rural physicians.

Quality Reporting for CY 2018 – New Resources to Help ACOFP Members

CMS announced [new resources](#) to help physicians and other eligible clinicians report for MIPS and APMs for **2018**. MIPS Reporting for CY 2018 starts January 2, 2019 and closes April 2, 2019

Need additional assistance? Contact ACOFP's partner www.MIPSPRO.com for a free phone consultation on your unique reporting situation. MIPSPRO, by Healthmonix, is a CMS Certified Registry for member reporting. Mention **ACOF**P and you will receive a 15% discount. Register with MIPSPRO early to ensure reporting before the deadline.

Check Your Individual or Alternative Payment Model (APM) Status

View Individual Status

- Go to: <https://qpp.cms.gov/participation-lookup>
- Enter your 10-digit National Provider Identifier (NPI)

View APM Status

- Log into the CMS [Quality Payment Program website](#) with your [EIDM credentials](#)
- Scroll to the Taxpayer Identification Number affiliated with your group
- Access the details screen to view the eligibility status of every clinician based on their NPI

Additional Questions

Contact the CMS Quality Payment Program Service Center:

- Email: QPP@cms.hhs.gov
- Phone: 1-866-288-8292 / TTY: 1-877-715-6222

Additional CMS References for the Final Rule 2019

[CMS Summary for 2019](#)

[Quick-Start Guide for 2019 MIPS Participation - Slides](#)