CMS Releases Final Rule for 2019 Medicare Physician Fee Schedule
Urgent Care Quality Measure Set Finalized

On November 1, the Centers for Medicare & Medicaid Services (CMS) finalized updates to payment policies and rates for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2019. This communication offers a summary of components of the PFS rule that have the potential to significantly impact urgent care medicine.

MERIT-BASED INCENTIVE PAYMENT SYSTEM

Quality Performance Category and Urgent Care Specialty Measure Set: CMS has finalized an urgent care specialty measure set for use in the Merit-based Incentive Payment System (MIPS) effective in 2019. Earlier this year, the College of Urgent Care Medicine (CUCM) and the Urgent Care Association (UCA), asked CMS to create a specialty measure set for urgent care providers. The measure set will help providers who care for Medicare patients in urgent care centers identify measures for fulfilling the quality component of MIPS.

Urgent care center providers are not required to report on the measure set nor must urgent care providers report on every measure in a set. A MIPS eligible clinician (or group) is only required to submit data on six measures within a measure specialty set. If a MIPS eligible clinician reports on less than six quality measures, they will be subjected to the measure validation process that will validate whether the clinician actually had less than six measures available or applicable to their scope of practice. Furthermore, MIPS eligible clinicians must report at least one outcome measure, or, if an applicable outcome measure is not available, a high-priority measure. The urgent care measure set includes several high-priority measures.

For the first time in 2019, CMS is allowing MIPS eligible clinicians and groups to submit data collected via multiple collection types within a performance category.

The requirements for the Quality Performance Category of MIPS will be largely unchanged for the 2019 performance period. The performance period will be the entire 2019 calendar year. The same data completeness requirements as Year 2 of MIPS, depending upon collection type, remain in place. Performance in the Quality performance category will comprise 45 percent of a MIPS eligible clinician's final score for the 2021 MIPS payment year.

Urgent Care Specialty Measure Set
Summary of Quality Data Completeness Requirements and Submission Criteria
Summary of Quality Data Submission Types
Example of Calculating Quality Score when Data is Submitted using Multiple Collection Types

Cost Category: CMS is finalizing its proposal to weight the cost performance category at 15 percent for the 2021 MIPS payment year. There are no submission requirements for cost measures, which are collected from claims data.

Improvement Activities Category: The performance period for improvement activities will continue as a 90-day continuous period during the calendar year. MIPS eligible clinicians must submit a yes response for activities within the improvement activities inventory. Improvement activities will constitute 15 percent of an eligible clinician's total MIPS performance score.

Promoting Interoperability Category *(previously known as Advancing Care Information)*:
Beginning with the 2019 performance period, MIPS eligible clinicians must use electronic health record technology certified to the 2015 Edition certification criteria.

For the 2019 performance period, CMS has finalized a new scoring methodology for the Promoting Interoperability category which is designed to reduce burden for clinicians and enable them to focus more on patient care. MIPS eligible clinicians will need to report on all of the required measures across all objectives to earn any score at all for the Promoting Interoperability performance category. Failure to report a required measure or reporting a "no" response on a "yes or no" response measure, unless an exclusion applies, will result in a score of zero.

2018 Promoting Interoperability Category Scoring, Measures and Objectives
Promoting Interoperability Scoring Methodology for 2019 and 2020 Performance Periods

Performance Threshold: CMS finalized a performance threshold of 30 points for the 2021 payment year, which doubles the required points from Year 2 to Year 3 of the program. Eligible clinicians must achieve at least 30 points to avoid a negative payment adjustment. CMS stated that it did not believe it was unreasonable to double the performance threshold and would encourage clinicians to gain experience with all MIPS performance categories. Beginning with the 2024 payment year, CMS will calculate the performance threshold using the mean or median of final performance scores.

Low-Volume Threshold and MIPS Opt-in Policy: Beginning with the 2021 MIPS payment year and beyond, eligible clinicians or groups will meet the low-volume threshold if they meet *at least one* of the following three criteria during the MIPS determination period: (1) those who have allowed charges for covered professional services less than or equal to $90,000; (2) those who provide covered professional services to 200 or fewer Part B-enrolled individuals; or (3) those who provide 200 or fewer covered professional services to Part B-enrolled individuals. MIPS eligible clinicians or groups who do not exceed the low-volume threshold are exempt from participating in MIPS.

For the first time, beginning with the 2021 MIPS payment year, if an individual eligible clinician or group exceeds at least one, but not all, of the low-volume threshold criteria, the individual clinician or group can opt to participate in MIPS by reporting on applicable measures and activities. In its comments to CMS, UCA stated that it favored retaining the low-volume MIPS exception, as well as creating the opt-in policy.

Small Practice Bonus: CMS has decided to increase the small practice bonus for the 2021 payment year. A small practice bonus of 6 bonus points will be added to the numerator of the Quality performance category for MIPS eligible clinicians in small practices if the MIPS eligible clinician submits data to MIPS on at least one quality measure. CMS had proposed a bonus of 3 points. The current bonus is 5 points and is added to the overall performance score.

EVALUATION AND MANAGEMENT PAYMENT AND DOCUMENTATION

CMS has finalized changes to evaluation and management (E/M) payment and documentation, but will not implement those changes until 2021. CMS says that the two-year delay will allow the Agency to "respond to the work done by the AMA and the CPT Editorial Panel, as well as other stakeholders" with regard to valuation of new or revised codes. In 2021, CMS will collapse into a single, blended payment rate office and outpatient E/M Levels 2-4. CMS had proposed a single payment rate for Levels 2-5. These payment changes will be accompanied by corresponding documentation changes. Collapsing levels 2-4 will have a redistributive effect on the specialties that bill E/M codes. For 2019, providers should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office and outpatient visits billed to Medicare.

CMS has also finalized, effective in 2019, changes to reduce E/M documentation redundancy.

- CMS has eliminated the requirement to document medical necessity of furnishing visits in the home rather than office.
- CMS will no longer require physicians to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated.

- Physicians must only document that they reviewed and verified information regarding chief complaint and history that is already recorded by ancillary staff or the patient.

In its comments, UCA requested that CMS allow time for a deliberative process by the physician community to more greatly inform any future E/M coding and payment changes and not finalize for E/M coding and payment changes for 2019.

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

CMS has finalized its proposal to make separate payment for brief communication technology-based services. The code will be described as 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, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)*. If the service originates from a related E/M service provided within the previous seven days by the same physician or other qualified health care professional, this service would be considered bundled into that previous E/M service and would not be separately billable. In instances when the service leads to an E/M service with the same physician or other qualified health care professional, this service would be considered bundled into the pre- or post-visit time of the associated E/M service, and therefore, would not be separately billable.

CMS is finalizing allowing real-time audio-only telephone interactions in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission. The national Medicare PFS payment rate for CY2019 will be $14.78.

Remote Evaluation of Pre-Recorded Patient Information

CMS is finalizing its proposal to make a separate payment for remote evaluation of pre-recorded patient information. The code will be described as G2010 *(Remote evaluation of recorded video and/or images submitted by an established patient [e.g., store and forward], including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment)*. When the review of the patient-submitted image and/or video results in an in-person E/M office visit with the same physician or qualified health care professional, this remote service will be considered bundled into that office visit and therefore will not be separately billable. In instances when the remote service originates from a related E/M service provided within the previous seven days by the same physician or qualified health care professional, this service will be considered bundled into that previous E/M service and also will not be separately billable. The national Medicare PFS payment rate for CY2019 will be $12.61.