



CMS has released the final rule for the CY 2019 Physician Fee Schedule and Quality Payment Program. Below are some provisions:

- **Conversion Factor for CY 2019:**
 - 36.0391 (Proposed: 36.0463)
- **Virtual Office Visits:**
 - Finalized policy
 - G2012 (Brief Communication technology-based service, e.g. virtual check-in, by a physician or other qualified healthcare professional who can report evaluation and management 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)
 - CMS accepted AAOE's recommendation not to be overly prescriptive in determining the types of communication devices that could be used for this code and is finalizing allowing audio-only real-time telephone interaction in addition to synchronous, two-way audio interactions that are enhanced with video and other kinds of data transmission.
 - This code can only be billed by the billing practitioner and may not involve only clinical staff.
 - CMS will not impose a frequency limitation on this service in the first year.
 - Verbal consent from the beneficiary is required for each service and must be documented in the medical record.
 - Effective January 1, 2019
 - 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 hours, not originating from a related E/M service provided within the previous 7 days not leading to an E/M service or procedure within the next 24 hours or soonest available appointment)
 - May be billed only for established patients
 - Effective January 1, 2019

- **Evaluation and Management:**

- For CY 2019 and CY 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits. Physicians should continue to use either the 1995 or 1997 versions of the E/M guidelines to document E/M office/outpatient visits billed to Medicare.
 - When relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.
 - For new and established patients for E/M office/outpatient visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified the information.
- Beginning in 2021, for E/M office/outpatient levels 2 through 5, CMS will allow a choice in documentation of the 1995 guidelines, 1997 guidelines, medical decision making, or time to determine the level billed.
 - Single payment rate for levels 2 through 4 (one each for new and established patients).
 - Finalized add-on payments for visit complexity inherently associated with primary care and non-procedural specialty care, as well as separate payment for extended visits via HCPCS G-codes.
- CMS is not finalizing a MPPR for separately identifiable office/outpatient E/M visits furnished on the same day as a global procedure.
- HCPCS G-Codes to Describe Podiatric E/M Visits
 - CMS will not finalize the proposal to adopt a separate E/M coding structure for podiatrists.
 - In 2021, podiatrists would bill using the same E/M coding structure applicable to other providers.

- **Quality Payment Program for CY 2019**

- PTs and OTs are required to participate starting January 1, 2019.
- Performance period for quality and cost categories will remain a full calendar year.
- Performance period for IA and PI categories will be 90 continuous days.

- In 2020 and beyond the performance period for IA will remain a continuous 90 days
- In 2020 the performance period for PI will remain a continuous 90 days
- 2015 Edition CEHRT will be required beginning with CY 2019.
- Qualified Clinical Data Registries
 - CMS is finalizing its proposal to require that QCDRs to have clinical expertise in medicine and quality measure development. This will be effective starting with the 2020 performance period.
 - CMS will not finalize a proposal to require QCDRs granting CMS a license to make their QCDR measures available to other QCDRs.