

# **CY 2019 Medicare Physician Fee Schedule Proposed Rule Summary**

On July 11, 2018, the Center for Medicare and Medicaid Services (CMS) released the proposed Medicare Physician Fee Schedule (MPFS) for 2019, which for the first time included proposals on the Quality Payment Program (QPP). The proposed rule updates payment policies and payment rates for Part B services furnished under the MPFS.

The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found <a href="https://example.com/here">here</a>. Comments on the proposal must be submitted by September 10, 2018. The final MPFS is typically published in early November with most of the provisions being effective January 1, 2019 unless stated otherwise.

The following summarizes the major payment policies in the proposed rule (a summary of the quality policies will be distributed separately). Highlighted in bold are specific topics and questions where CMS is seeking comments.

# **Conversion Factor and Specialty Impact**

The conversion factor for 2019 is \$36.0463, a slight increase over 2018. The Medicare Access and CHIP Reauthorization Act (MACRA) had authorized a 0.50 percent update for CY 2018, but this was cut in half by the Balanced Budget Act of 2018.

Table 94 (see Attachment 1), extracted from the rule, provides a summary of the impact of the proposed changes in the rule by specialty. The changes in the rule are budget-neutral in the aggregate which explains why the impact for all physicians is shown as zero. The 2019 proposed rule is showing changes in the range of minus 5% to plus 4%, with neurology experiencing a 2% decrease.

# **Proposed Values for Neurology Procedural Codes for 2019**

Attached to this summary are charts showing the proposed relative value units and national average payments for the major medical and surgical services provided at epilepsy centers and for evaluation and management (E/M) services. In general, the relative value units and payment for procedural services provided by neurologists remains stable in 2019. There is a new code taking effect for ECoG of the monthly review of data for patients on the RNS system and the VNS analysis and programming codes have been changed for 2019. Major changes are being proposed for E/M, which will negatively impact payment for most neurologists and are discussed in detail in this summary.

New Electrocorticography Code for RNS (CPT code 96X00)

A new CPT code will take effect on January 1, 2019 for an Electrocorticogram from an implanted brain neurostimulator pulse generator/transmitter, including recording, with interpretation and written report, up to 30 days. This code is to be used for the non-face-to-face service to review a month's worth or more of stored data from patients on the RNS system.

The AMA RUC recommended a work RVU of 2.30 for this service. CMS disagrees with the RUC recommended RVUs for this service and is proposing a work RVU of 1.98. CMS is basing its decision on the fact that the top reference code used by physicians completing the RUC survey for this new service

was 95957, which has work RVUs of 1.98 and the time for the two services is nearly identical. NAEC will comment on this proposal and ask CMS to accept the RUC recommended work values for this service.

#### Revisions to VNS Codes

The VNS codes 95974 and 95975 will be deleted as of January 1, 2019 and the services will be described by two new codes 95X83 – Electronic analysis of implanted neurostimulator pulse generator/transmitter, by physician or other qualified health care professional; with simple (1 to 3 parameters) cranial nerve neurostimulator pulse generator/transmitter programing by physician or other qualified health care professional; and 95X84 - Electronic analysis of implanted neurostimulator pulse generator/transmitter, by physician or other qualified health care professional; with complex (more than 3 parameters) cranial nerve neurostimulator pulse generator/transmitter programing by physician or other qualified health care professional. The former codes were based on a time parameter and the new codes are defined as being simple vs. complex, so changes in the values of the codes were anticipated. Unfortunately, CMS is not accepting the RUC recommendations for physician work of the new services and is proposing lower values as shown below. In commenting on the rule, NAEC will ask that CMS accept the RUC recommendations:

Code	RUC Recommendation	CMS Proposal
95X83	0.95 RVUs	0.73 RVUs
95X84	1.19 RVUs	0.97 RVUs

# **Evaluation & Management Proposals**

In this rule, CMS proposed significant changes to how E/M services will be paid and documented. The proposed changes to the documentation guidelines are intended to reduce administration burden and are tied to the payment reduction. The agency is proposing to create a single payment rate for level 2 through 5 new and established patient, office and outpatient visit services. Providers would only be required to document a level 2 office/outpatient visit regardless of the level of E/M service provided. The proposals for documentation changes, as well as other payment changes, are detailed below.

# E/M Documentation Guidelines

In the CY 2018 proposed rule, CMS solicited comments on how to reduce the administrative burden associated with the 1995 and 1997 documentation guidelines for E/M office visits. Stakeholders have maintained that the guidelines are too complex, ambiguous, fail to meaningfully distinguish differences among code levels and are not updated for changes in technology, especially EHR use. CMS solicited additional feedback from stakeholders throughout the year and received substantially different recommendations by specialty. Also, CMS concluded that the history and physical exam portions of the guidelines are significantly outdated with respect to current clinical practice.

#### CY 2019 Proposed Policies

1) Eliminating Extra Documentation Requirements for Home Visits

Medicare pays for home E/M visits (CPT codes 99341 through 99350) at a slightly higher rate than for office visits. Physicians must document the medical necessity of the home visit in lieu of an office or outpatient visit. CMS is proposing to remove this documentation requirement.

2) Public Comment Solicitation on Eliminating Prohibition on Billing Same-Day Visits by Practitioners of the Same Group and Specialty

Currently, Medicare will not pay for two E/M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems. CMS now believes there are certain instances where this no longer makes sense and the policy inconveniences patients unnecessarily and is seeking comments.

3) Documentation Changes for Office or Other Outpatient E/M Visits and Home Visits

CMS is proposing to allow physicians to <u>choose how to document medical necessity through one of the following: medical decision making (MDM), time, or the current 1995 and 1997 guidelines to document the appropriate level E/M visit. All providers will be subject to the proposed E/M payment changes regardless of how they choose to document visits. CMS has linked the documentation and payment proposals.</u>

**MDM** - Because CMS is proposing to create a single payment rate for levels 2 through 5 E/M office and outpatient visits, only a level 2 visit must be documented to be eligible for reimbursement. If the provider were to choose to document based on MDM alone, Medicare would only require documentation supporting straightforward medical decision-making measured by two of these three: minimal problems, data review, and risk. CMS is proposing to allow practitioners to use MDM in its current form for documentation.

**Time** - CMS is proposing to allow providers to use time as a documentation standard for E/M visits. The proposal would require the documentation of the time the billing practitioner spends face-to-face with the patient, as well as the medical necessity of the visit. The agency has outlined three ways to document time for the new E/M payment:

- 1. CMS has proposed that the typical time for the new E/M payment level is 31 and 38 minutes for established and new patients respectively. These times are the weighted averages of the intraservice times across the current E/M visit utilization.
- 2. Apply the CPT codebook rule that to bill the service the unit of time is attained when the midpoint is passed (15.5 mins and 19 mins, respectively for established and new patients); or
- 3. Require documentation that the typical time for the CPT code that is reported was spent face-to-face by the billing practitioner with the patient. The total amount of time spent by the provider face-to-face with a patient would inform the level of E/M visit coded.

1995 and 1997 Guidelines - Stakeholders have recommended that CMS should not require documentation of information in the provider's note that is already present in the medical record, particularly for history and exam. If a provider chooses to continue to document based on the 1995 and 1997 guidelines, the agency proposes several changes. CMS proposes to further simplify these requirements by requiring documentation only focus on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a defined list of required elements such as review of a specified number of systems and family/social history. The agency asks if there may be ways to implement similar provisions for any aspects of MDM or for new patients if prior data is available through the EHR or data exchange. For new and established patients, CMS proposes that providers will no longer be required to re-enter information in the record regarding the chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner would only be required to indicate he reviewed and verified the information.

# 4) Simplifying Payment Amounts

In conjunction with CMS' proposal to simplify the E/M documentation requirements, the agency is proposing to simplify the office-based and outpatient E/M payment rates and create new add-on codes to capture the differential resources involved in furnishing certain types of E/M visits. The agency proposes to pay a single rate for the level 2 through 5 E/M visits for new and established patients. CMS will maintain the current code set even though they believe that the distinctions between Medicare visits are not well reflected by the E/M visit coding and does capture distinctions in services and resources.

CMS proposes the following values for the single new and established E/M payment rates, which are based on the average of the current inputs for the codes weighted by 5 years of utilization data.

# New patient office visit (old CPT codes 99202-99205)

- 1.90 RVUs for physician work
- 37.79 minutes of physician time
- \$24.98 direct practice expense costs

# Established patient office visit (CPT codes 99212-99215)

- 1.22 RVUs for physician work
- 31.31 minutes of physician time
- \$20.70 direct practice expense costs

# **Preliminary Comparison of Payment Rates**

HCPCS	CY2018 Non-facility	CY2019 Non-facility Payment				
Code	Payment Rate	Rate under the Proposal				
New Pati	ent Office Visits					
99201	\$45	\$44				
99202	\$76	\$135				
99203	\$110					
99204	\$167					
99205	\$211					
Establish	Established Patient Office Visits					
99211	\$22	\$24				
99212	\$45	\$93				
99213	\$74					
99214	\$109					
99215	\$148					

The agency proposes to make additional adjustments to E/M policies to better account for the costs of providing E/M services: (1) an E/M multiple procedure payment reduction (MPPR) to account for duplicative resource costs when E/M visits and procedures on the MPPR list are billed together; (2) HCPCS G-code add-ons to recognize additional relative resources for primary care visits and inherent visit complexity that require additional work beyond that which is accounted for in the single payment rates for new and established patient level 2 through 5 visits; (3) HCPCS G-codes to describe podiatric E/M visits; (4) an additional prolonged face-to-face services add-on G code; and (5) a technical modification to the PE methodology to stabilize the allocation of indirect PE for visit services.

# • Multiple Procedure Payment Reduction

CMS is proposing to reduce payment by 50 percent for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E/M visit, currently identified on the claim using modifier -25.

# Proposed HCPCS G-code Add-ons to Recognize Additional Relative Resources for Certain Kinds of Visits

The proposed add-on codes address the additional resources required to furnish the face-to-face portion of office visits performed by a primary care physician or specialist who primarily reports level 4 and 5 visit codes. These add-on codes can be billed with every new and established patient office visit.

<u>Primary care add-on</u>: GPC1X (Visit complexity inherent to evaluation and management associated primary medical care services that serve as the continuing focal point for all needed health care services). This code could also be reported for other forms of face-to-face care management, counseling, or treatment of acute or chronic conditions not accounted for by other coding. CMS is not proposing any specialty limitations on billing this code. The physician work RVUs are .07 and the national average payment rate for this service if provided in a physician office is \$5.41 or in a hospital outpatient department \$3.97.

<u>Specialty add-on:</u> GCGOX (Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care). The agency believes the listed specialties apply predominantly non-procedural approaches to complex conditions that are intrinsically diffuse to multi-organ or neurologic disease.

To value GCGOX, CMS proposes a crosswalk to 75 percent of the work and time of CPT code 90785 (Interactive complexity), an add-on code that may be billed when a psychotherapy or psychiatric service requires more resources due to the complexity of the patient. For this add-on service, CMS is proposing physician work RVUs of 0.25 and a national payment rate of \$13.70 for services provided in both a physician office or outpatient department.

#### Technical PE Modification for the Single Rate New and Established Patient E/M Services

CMS recognizes the distribution of specialties across E/M services would change as a result of this proposal and is concerned about the impact on indirect PE allocations. The agency is proposing to create a single PE/HR value for E/M visits of \$136 based on the average of the PE/HR across all specialties that bill E/M codes weighted by the volume of those specialties' allowed E/M services. If this proposal is finalized, CMS will consider revisiting this PE/HR after several years of claims data becomes available.

# • Proposed HPCPS G-Code for Prolonged Services

CMS proposes to create a new HCPCS G-code GPRO1 (Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; 30 minutes). This service is half the physician time assigned to CPT code 99354 (Prolonged evaluation and management or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; first hour), so CMS proposes a work RVU of 1.17, half of the value of 99354. The national average payment rates for the prolonged service add-on code provided in a physician office is \$67.41 and in the hospital outpatient department it is \$63.08.

Based on the CPT codebook provision that for times services a unit of time is attained when the mid-point is passed, providers could bill this after they spend an additional 16 minutes with the patient.

# Impact of proposed changes to E/M policies

CMS modeled the potential impacts of these E/M-related changes (single level 2 through 5 payment rate, application of the MPPR, the primary care and specialty add-on codes, and the PE adjustments) at the specialty-level, but cautions that these estimates are imprecise because the model did not account for the full range of technical changes in input data.

Reimbursement for a Level 4 Established Patient Office Visit				
CY 2018	Policies Proposed in the Rule			
\$109	\$165			
	*The new payment rate for level 2 through 5 established patient office visit, GPRO1 and			
	GPC1X (primary care add-on)			
	\$177			
	*The new payment rate for level 2 through 5 established patient office visit, GPRO1, and			
	GCG0X (specialty care add-on)			

The AMA prepared a more in-depth analysis of the impact of the proposed changes to E/M services on specific specialties, which we have included in this summary as Attachment 2.

### Teaching Physician Documentation Requirements for Evaluation and Management Services

CMS has received feedback that the documentation requirements for E/M services provided by teaching physicians are burdensome and duplicative of notes previously made by residents or other members of the team. The agency is proposing to require that the medical record must document that the teaching physician was present at the time the service is delivered and it can be documented in the note made by the physician, resident, or nurse.

CMS is also proposing to eliminate the requirement for the teaching physician to document the extent of his own participation in the review and direction of the services furnished to each beneficiary and instead allow the resident or nurse to document the extent of the teaching physician's participation as well.

#### Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services

The Social Security Act limits the Secretary's ability to expand telehealth services. However, the recently passed Bipartisan Budget Act of 2018 (BBA) modified the requirements, particularly those for originating sites for certain services, including home dialysis end-stage renal disease (ESRD)-related services, services from practitioners who participate in Accountable Care Organizations (ACOs), and acute stroke-related services. Besides implementing the provisions of the BBA, CMS is proposing to pay separately for other telehealth services.

Also, CMS proposes to expand access to medical care using telecommunications technology by proposing to cover a number of new services and is proposing new codes to bill for these services under the PFS: Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCI1) and Remote Professional Evaluation of Recorded Video and/or Images Technology Submitted by the Patient, e.g. Store and Forward Services (HCPCS code GRAS1).

CMS is also proposing to pay separately for Chronic Care Remote Physiologic Monitoring (CPT codes 990X0, 990X1, and 994X9) and Interprofessional Internet Consultation (CPT codes 994X6, 994X0, 99446, 99447, 99448, and 99449). The agency believes these codes will result in improved payment accuracy for primary care and care management services.

## **Valuation of Additional Codes**

Interprofessional Internet Consultation (CPT code 994X0, 994X6, 99446, 99447, 99448, 99449)

CPT revised 4 existing codes and created 2 new codes to describe interprofessional telephone/internet/electronic medical record consultation services. CPT codes 99446-99449 had previously considered to be bundled services and were not separately payable. CMS is proposing to convert these to active codes based on changes in medical practice and technology. CMS affirmed the work RVUs for the existing codes and proposed the RUC-recommended value for 994X0 and made a different recommendation for 994X6. The RVUs and national payment rates for these codes are delineated in the attached chart.

# Remote pre-recorded services (HCPCS code GRAS1)

CMS is proposing to pay separately for remote services when a physician uses pre-recorded video and/or images submitted by the patient for evaluation of the patient's condition. GRAS1 (Remote evaluation of recorded video and/or images submitted by the patient (e.g. store and forward), including interpretation with verbal 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). The recommended RVUs for this service are 0.18 with a national average payment rate of \$12.98 for physician office-based services and \$10.09 for services provided in the hospital outpatient department.

Brief Communication Technology-based Service, e.g. Virtual Check-in (HCPCS code GVCI1)

CMS is proposing to create a new G-code to pay for brief communication technology-based services. GVCI1 (Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health professional who may 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)

The descriptor and valuation were based on CPT code 99441 for telephone evaluation and management services. CMS is proposing a work RVU of 0.25 based on a direct crosswalk to 99441. The national average payment rate for the physician office-based service is \$15.14 and for the hospital outpatient based physician service it is \$13.34.

#### **Changes to Direct PE Inputs for Specific Services**

Market-Based Supply and Equipment Pricing Update

The Protecting Access to Medicare Act of 2014 (PAMA) provided that the Secretary may collect or obtain information from any eligible professional on the resources directly or indirectly related to the delivery of fee schedule services. Under this authority, CMS hired a contractor to conduct a market research study to update the direct PE inputs for supply and equipment pricing for CY 2019. These prices were last updated in 2004-2005. A report with updated pricing for approximately 1300 supplies and 750 equipment items has been submitted and is available in the downloads section that accompanies the proposed rule.

Based on this report, CMS is proposing to adopt updated direct PE input prices for supplies and equipment over a 4-year period beginning in CY 2019 because of the potentially significant changes in payment that would occur. The pricing for many equipment and supply items is increasing as a result. The agency is proposing to use a 25/75 percent split between new and old pricing in year one, 50/50 in year two, 75/25 in year three, and 100/0 in year four. Along with the full report, a spreadsheet showing the phased in values is available for download. The CY 2019 PE values found in Addendum B reflect this 25/75 pricing phase in. New supply and equipment codes that are implemented during this 4-year period will be fully implemented with no transition.

To maintain relativity between the clinical labor, supplies, and equipment portions of the PE methodology, CMS want to update the rates for clinical labor staff and seeks comment on whether to update clinical labor wages used to develop PE RVUs in future calendar years during the transition period or whether it would be more appropriate to do at the conclusion of the transition period.

# <u>Payment for Nonexcepted Items and Services Furnished by Nonexcepted Off-Campus Provider-Based</u> <u>Departments of Hospitals</u>

Starting in January 2017, CMS no longer recognized under the Hospital Outpatient Prospective Payment System (OPPS) certain items and services furnished by certain off-campus provider-based departments (PBDs) and paid for these services under the fee schedule. In 2017, payment for these services were paid at 50% of the OPPS payment rate and in 2018 payment was set at 40% of the OPPS rate. This payment policy is called the PFS Relativity Adjuster. In addition, all claims for these services were submitted with specific modifiers, so that CMS could determine future payment levels that would be more appropriate for PBDs.

For CY 2019, CMS is proposing to continue applying the PFS Relativity Adjuster of 40%, which means that nonexcepted items and services furnished by nonexcepted off-campus PBDs will be reimbursed at 40% of the OPPS payment rate. CMS is also maintaining the same geographic adjustment and beneficiary cost sharing policies that were in effect in CY 2018.

Note: Services that are "excepted" from this payment change are provided in: dedicated emergency departments; off-campus PBDs that were billing for covered outpatient department services furnished prior to November 2, 2015; in "on campus" PBDs or within 250 yards of the hospital or a remote location of the hospital. All services that do not meet these requirements are considered "non-excepted."

# Part B Drugs: Application of Add-on Percentage for certain WAC-based payments

Drugs are typically reimbursed under Medicare Part B at the average sales price (ASP) for the drug or biological plus a 6% add-on payment. Part B payments are based on the wholesale acquisition cost (WAC) of the drug or biological when ASP is not available during the first quarter of sales or when Medicare Administrative Contractors determine pricing, which is for drugs not appearing on the ASP pricing files or for new drugs. The WAC of a drug typically exceeds the ASP, as it does not include any prompt pay or other discounts, rebates or reductions in price included in the ASP.

CMS is proposing, effective January 1, 2019, to reduce payment for drugs when WAC-based payments are being used by reducing the add-on percentage to 3% (from 6%). The proposal is based on a 2014 OIG Report and recommendations from MedPAC to achieve greater parity between ASP-based acquisition costs and WAC-based payments for Part B drugs.

#### **Physician Self-Referral Law**

The physician self-referral law prohibits a physician from making referrals for certain designated health services (DHS) payable by Medicare to an entity with which he or she (or an immediate family member) has a financial relationship (ownership or compensation), unless an exception applies. The law also prohibits the entity from filing claims with Medicare (or billing another individual, entity, or third-party payer) for those referred services.

The statute establishes specific exceptions and CMS is proposing revisions which mirror provisions recently made in the BBA, while also addressing differences in the statutory and regulatory language. With this, CMS clarifies the requirements for written agreements and signatures. CMS codifies the agency's existing policy that allows a collection of documents to satisfy the requirement for a compensation agreement to be in writing.

CMS also proposes that the signature requirement can be satisfied if the compensation agreement complies with all criteria of the exception and also is obtained "90 consecutive calendar days immediately following the date" of a required signature.

# ATTACHMENT 1

TABLE 94: CY 2019 PFS Estimated Impact on Total Allowed Charges by Specialty

(A)	(B)	(C)	(D)	(E)	(F)
Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact*
TOTAL	\$92,173	0%	0%	0%	0%
ALLERGY/IMMUNOLOGY	\$238	1%	-6%	0%	-5%
ANESTHESIOLOGY	\$1,889	0%	0%	0%	0%
AUDIOLOGIST	\$67	0%	0%	-1%	-1%
CARDIAC SURGERY	\$293	-1%	-1%	1%	-1%
CARDIOLOGY	\$6,590	0%	-1%	0%	-1%
CHIROPRACTOR	\$749	0%	1%	0%	0%
CLINICAL PSYCHOLOGIST	\$770	0%	2%	0%	2%
CLINICAL SOCIAL WORKER	\$725	0%	2%	0%	2%
COLON AND RECTAL SURGERY	\$165	0%	1%	0%	1%
CRITICAL CARE	\$340	-1%	0%	0%	0%
DERMATOLOGY	\$3,477	1%	-2%	0%	-1%
DIAGNOSTIC TESTING FACILITY	\$728	0%	-4%	0%	-4%
EMERGENCY MEDICINE	\$3,110	0%	0%	0%	0%
ENDOCRINOLOGY	\$480	0%	-1%	0%	-1%
FAMILY PRACTICE	\$6,176	0%	1%	0%	1%
GASTROENTEROLOGY	\$1,750	-1%	1%	0%	1%
GENERAL PRACTICE	\$423	0%	1%	0%	1%
GENERAL SURGERY	\$2,079	0%	0%	0%	1%
GERIATRICS	\$196	-2%	1%	0%	-1%
HAND SURGERY	\$213	2%	1%	0%	2%
HEMATOLOGY/ONCOLOGY	\$1,737	-1%	-3%	0%	-4%
INDEPENDENT LABORATORY	\$640	0%	4%	0%	4%
INFECTIOUS DISEASE	\$645	-1%	1%	0%	0%
INTERNAL MEDICINE	\$10,698	0%	1%	0%	1%
INTERVENTIONAL PAIN MGMT	\$863	2%	1%	0%	3%
INTERVENTIONAL RADIOLOGY	\$384	1%	-1%	0%	0%
MULTISPECIALTY CLINIC/OTHER PHYS	\$148	-1%	0%	0%	-1%
NEPHROLOGY	\$2,182	-1%	0%	0%	-1%
NEUROLOGY	\$1,521	-1%	-1%	0%	-2%
NEUROSURGERY	\$798	0%	0%	1%	1%
NUCLEAR MEDICINE	\$50	-1%	-1%	0%	-1%
NURSE ANES / ANES ASST	\$1,163	0%	0%	0%	0%
NURSE PRACTITIONER	\$4,043	1%	2%	0%	2%
OBSTETRICS/GYNECOLOGY	\$635	3%	1%	0%	4%

(A)	(B)	(C)	(D)	(E)	(F)
Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact*
OPHTHALMOLOGY	\$5,437	0%	-1%	0%	-1%
OPTOMETRY	\$1,301	1%	0%	0%	1%
ORAL/MAXILLOFACIAL SURGERY	\$67	1%	-2%	0%	-1%
ORTHOPEDIC SURGERY	\$3,730	1%	0%	0%	1%
OTHER	\$31	0%	5%	0%	4%
OTOLARNGOLOGY	\$1,206	2%	-3%	0%	-1%
PATHOLOGY	\$1,158	0%	-1%	0%	-1%
PEDIATRICS	\$61	-1%	0%	0%	-1%
PHYSICAL MEDICINE	\$1,102	-1%	0%	0%	-1%
PHYSICAL/OCCUPATIONAL THERAPY	\$3,930	0%	-1%	0%	-1%
PHYSICIAN ASSISTANT	\$2,447	1%	0%	0%	1%
PLASTIC SURGERY	\$373	1%	0%	0%	1%
PODIATRY	\$1,958	-1%	0%	0%	-2%
PORTABLE X-RAY SUPPLIER	\$98	0%	1%	0%	1%
PSYCHIATRY	\$1,177	0%	2%	0%	3%
PULMONARY DISEASE	\$1,709	-2%	0%	0%	-2%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	\$1,760	0%	-2%	0%	-2%
RADIOLOGY	\$4,891	0%	0%	0%	0%
RHEUMATOLOGY	\$540	-1%	-3%	0%	-4%
THORACIC SURGERY	\$356	-1%	-1%	1%	-1%
UROLOGY	\$1,733	2%	1%	0%	3%
VASCULAR SURGERY	\$1,144	0%	-2%	0%	-1%
* Column F may not equal the sum of o	columns C, D, and E	due to rounding			

# **ATTACHMENT 2**

# Estimated Impact of CY2019 Evaluation and Management Proposed Policy by Medicare Specialty

\*Includes CPT Codes 99201-99215, GCG0X, GCG1X, GPD0X and GPD1X, but does not include GPR01 - prolonged service
Analysis uses Estimated CY2017 Medicare Utilization and CY2019 Medicare CF for both "Current Method" and "Proposed Method"; E/M MPPR Estimate based on 2016 Medicare Carrier 5% Standard Analytic File
Excludes specialties with less than \$1 million in CY2017 allowed charges for 99201-99215 or claims with unknown specialty designation

Medicare Designated Specialty	Total Medicare Payment for Office Visits w/o Policy Changes (Using CY2018 Total RVUs)	Change in Payment Due To Proposed E/M Collapse Policy (includes G codes*)	Additional Change in Payment Due to E/M MPPR Policy	Net Change Due to E/M Collapse and E/M MPPR Policies	Total Medicare Payment for Office Visits Under Proposed Method (E/M Collapse and E/M MPPR) (Using Proposed CY2019 Total RVUs)	Percent Change in Payment for Office Visits (Both E/M Collapse and E/M MPPR Policies)
TOTAL	\$ 23,298,623,446					
HOSPICE	\$ 6,491,871			\$ (1,299,888)		-20%
HEMATOLOGY	\$ 35,814,877	1		\$ (5,693,026)		-16%
GYNECOLOGY/ONCOLOGY MEDICAL ONCOLOGY	\$ 28,857,336 \$ 217,094,796				\$ 24,312,915	-16% -14%
NEUROPSYCHIATRY	\$ 217,094,796	1 ' ' '		. , , ,	1 ' '	-14%
NEPHROLOGY	\$ 366,158,222	<u> </u>		\$ (47,506,478)		-13%
NUCLEAR MEDICINE	\$ 3,261,367			\$ (418,133)		-13%
CARDIAC ELECTROPHYSIOLOGY	\$ 123,640,581	\$ (15,324,933)	\$ (146,856)	\$ (15,471,789)	\$ 108,168,792	-13%
CRITICAL CARE (INTENSIVISTS)	\$ 35,990,339			\$ (4,426,144)		-12%
RADIATION ONCOLOGY	\$ 85,243,662	\$ (9,893,434)	\$ (574,960)	\$ (10,468,394)	\$ 74,775,268	-12%
PODIATRY	\$ 645,600,644	\$ (10,733,858)	\$ (65,687,368)	\$ (76,421,226)	\$ 569,179,418	-12%
INTERVENTIONAL CARDIOLOGY	\$ 230,977,054				\$ 205,458,505	-11%
PULMONARY DISEASE	\$ 519,566,122		. , , ,	\$ (57,277,547)		-11%
CARDIAC SURGERY	\$ 23,265,687			\$ (2,475,041)		-11%
THORACIC SURGERY	\$ 34,448,176			\$ (3,446,528)		-10%
SLEEP MEDICINE	\$ 18,791,073 \$ 87,007,974		\$ (3,618)	\$ (1,824,006) \$ (7,948,821)		-10%
INFECTIOUS DISEASE				. , , ,	,,	-9%
GERIATRIC MEDICINE COLORECTAL SURGERY	\$ 62,649,142 \$ 32,609,046			\$ (5,688,949) \$ (2,566,086)		-9% -8%
SURGICAL ONCOLOGY	\$ 18,788,106		\$ (285,170)	\$ (2,363,357)		-7%
PHYSICAL MEDICINE AND REHABILITATION	\$ 296,738,502			\$ (15,563,961)	\$ 281,174,540	-5%
DERMATOLOGY	\$ 883,036,919		\$ (251,123,409)	\$ (41,878,865)		-5%
NEUROLOGY	\$ 670,721,588	\$ (24,948,472)	\$ (5,341,041)	\$ (30,289,513)	\$ 640,432,075	-5%
PERIPERAL VASCULAR DISEASE	\$ 3,031,756	\$ (80,774)	\$ (35,394)	\$ (116,168)	\$ 2,915,588	-4%
OPHTHALMOLOGY	\$ 515,715,805	\$ 3,971,043	\$ (23,714,332)	\$ (19,743,289)	\$ 495,972,516	-4%
ANESTHESIOLOGY	\$ 169,519,002	\$ (204,291)	\$ (5,065,536)	\$ (5,269,827)	\$ 164,249,175	-3%
SPORTS MEDICINE	\$ 42,181,673		\$ (4,861,167)	\$ (1,277,920)	\$ 40,903,753	-3%
GERIATRIC PSYCHIATRY	\$ 5,170,221	• • • • • • • • • • • • • • • • • • • •		\$ (156,210)		-3%
CERTIFIED CLINICAL NURSE SPECIALIST	\$ 29,322,926			\$ (764,530)		-3%
EMERGENCY MEDICINE GASTROENTEROLOGY	\$ 164,829,846 \$ 494,407,166			\$ (3,804,304) \$ (11,066,582)		-2% -2%
PREVENTIVE MEDICINE	\$ 6,380,418			\$ (136,985)		-2%
CERTIFIED REGISTERED NURSE ANESTHETIST	\$ 1,206,868			\$ (24,260)		-2%
ADDICTION MEDICINE	\$ 4,621,434		. , , ,	\$ (69,570)		-2%
PATHOLOGY	\$ 2,881,831	. , , ,	\$ (373,663)	\$ (42,297)	, ,	-1%
RHEUMATOLOGY	\$ 375,417,278	\$ 13,205,481	\$ (17,540,236)	\$ (4,334,755)	\$ 371,082,523	-1%
PEDIATRIC MEDICINE	\$ 25,857,819	\$ 269,554	\$ (484,578)	\$ (215,024)	\$ 25,642,796	-1%
ENDOCRINOLOGY	\$ 374,423,628	\$ (1,129,450)	\$ (186,831)			0%
INTERNAL MEDICINE	\$ 3,871,679,750		\$ (24,729,341)	\$ 6,595,938	, , ,	0%
INTERVENTIONAL RADIOLOGY	\$ 9,484,370		\$ (413,873)	\$ 55,861	\$ 9,540,231	1%
NEUROSURGERY	\$ 116,272,265		\$ (323,774)	\$ 1,467,620		1%
HEMATOLOGY/ONCOLOGY	\$ 697,545,442 \$ 3,606,747,571					1%
FAMILY MEDICINE OSTEOPATHIC MANIPULATIVE MEDICINE	\$ 3,606,747,571 \$ 20,490,031	·				2% 2%
ORTHOPEDIC SURGERY	\$ 947,571,929	· · · · · · · · · · · · · · · · · · ·	. , , ,			3%
CARDIOLOGY	\$ 1,673,787,386					3%
PSYCHIATRY	\$ 428,733,813					3%
GENERAL SURGERY	\$ 331,303,718					5%
NURSE PRACTITIONERS	\$ 1,441,181,453	\$ 93,149,384	\$ (25,035,363)	\$ 68,114,021	\$ 1,509,295,474	5%
HAND SURGERY	\$ 61,951,012					5%
DIAGNOSTIC RADIOLOGY	\$ 12,237,942					6%
PHYSICIANS ASSISTANT	\$ 880,931,609					6%
OTOLARYNGOLOGY	\$ 483,766,537		. , , ,	, , , , , ,		6%
ORAL SURGERY	\$ 8,519,498	, ,		,	· · · · · · · · · · · · · · · · · · ·	6%
GENERAL PRACTICE  VASCULAR SURGERY	\$ 181,231,116 \$ 115,959,089					6% 7%
PAIN MANAGEMENT	\$ 115,959,089	· · · · · · · · · · · · · · · · · · ·	. , , ,			9%
OPTOMETRY	\$ 273,100,554	·	. , , ,	. , ,		9%
INTERVENTIONAL PAIN MANAGEMENT	\$ 168,203,323					9%
PLASTIC AND RECONSTRUCTIVE SURGERY	\$ 55,565,227					10%
UROLOGY	\$ 752,497,473					11%
ALLERGY/IMMUNOLOGY	\$ 95,801,235					13%
CERTIFIED NURSE MIDWIFE	\$ 2,144,561	\$ 312,479	\$ (20,735)	\$ 291,744	\$ 2,436,305	14%
OBSTETRICS/GYNECOLOGY	\$ 225,275,520					17%
MAXILLOFACIAL SURGERY	\$ 4,558,435	\$ 978,386	\$ (146,599)	\$ 831,787	\$ 5,390,222	18%