

**DEPARTMENT OF HEALTH AND HUMAN SERVICES****Centers for Medicare & Medicaid Services****42 CFR Parts 405, 410, 411, 414, 415, 425, and 495****[CMS-1693-CN2]****RIN 0938-AT31**

Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; Quality Payment Program--Extreme and Uncontrollable Circumstance Policy for the 2019 MIPS Payment Year; Provisions from the Medicare Shared Savings Program--Accountable Care Organizations--Pathways to Success; and Expanding the Use of Telehealth Services for the Treatment of Opioid Use Disorder under the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act; Correction

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule; correction.

SUMMARY: This document corrects technical errors in the “Evaluation and Management Services” provisions that appeared in the final rule with comment period published in the **Federal Register** on November 23, 2018, concerning changes to the Medicare physician fee schedule (PFS) and other Medicare Part B payment policies to ensure that our payment systems are updated to reflect changes in medical practice and the relative value of services, as well as changes in the statute.

DATES: These corrections are effective on March 14, 2019.

FOR FURTHER INFORMATION CONTACT:

Jamie Hermansen, (410) 786-2064, for any physician payment issues not identified below.

Michael Soracoe, (410) 786-6312, for issues related to relative value units (RVUs).

Lindsey Baldwin, (410) 786-1694, and Emily Yoder, (410) 786-1804, for issues related to communication technology-based services.

Pamela West, (410) 786-2302, for issues related to therapy services.

SUPPLEMENTARY INFORMATION:

I. Background

In FR Rule Doc. No. 2018-24170, published November 23, 2018 (83 FR 59452 through 60303), there were a number of technical errors that are identified and corrected in the Correction of Errors section below. The provisions in this correction document are effective as if they had been included in the document published November 23, 2018. Accordingly, the corrections are effective January 1, 2019.

II. Summary of Errors

Due to a technical error, on page 59454, in the second column, following the first full paragraph, we inadvertently did not include the heading for Section II. of the preamble “Provisions of the Final Rule and Analysis of and Responses to Public Comments for PFS”, and the subsection heading and preamble language for “A. Background”. This subsection provides background information regarding Medicare payment for physicians' services under the PFS. We are correcting this error by adding the language described below in section IV. 1. of this correction notice, to page 59454, in the second column, following the first partial paragraph.

Due to a technical error, the RVUs associated with the 53 modifier (discontinued procedures) for CPT codes 44388 and 45378 and HCPCS codes G0105 and G0121 were inadvertently not calculated at half of the RVUs for their respective non-53 modifier codes. The RVUs that result from the correction of this error are reflected in the updated Addendum B available on the CMS Website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>

On page 59575, column 3, 3rd full paragraph, we incorrectly stated that CPT code 99457 could not be furnished by auxiliary personnel, and instead must be performed by the billing practitioner. CPT code 99457 may be furnished by auxiliary personnel, incident to the billing practitioner's professional services.

On page 60070, column 3, 1st full paragraph, in our discussion of quantifying burden reduction for therapy services related to the discontinuation of functional reporting, we incorrectly referenced section II.M. rather than section II.L. of the final rule.

III. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** to provide a period for public comment before the provisions of a rule take effect in accordance with section 553(b) of the Administrative Procedure Act (APA) (5 U.S.C. 553(b)).

However, we can waive this notice and comment procedure if the Secretary finds, for good cause, that the notice and comment process is impracticable, unnecessary, or contrary to the public interest, and incorporates a statement of the finding and the reasons therefore in the notice.

Section 553(d) of the APA ordinarily requires a 30-day delay in effective date of final rules after the date of their publication in the **Federal Register**. This 30-day delay in

effective date can be waived, however, if an agency finds for good cause that the delay is impracticable, unnecessary, or contrary to the public interest, and the agency incorporates a statement of the findings and its reasons in the rule issued.

We find it unnecessary to undertake notice and comment rulemaking because this notice merely provides technical corrections to the regulations. Therefore, we find good cause to waive notice and comment procedures.

IV. Correction of Errors

In FR Rule Doc. No. 2018-24170, appearing on page 59452 in the *Federal Register* of Friday, November 23, 2018, make the following corrections:

1. On page 59454, in the second column; following the first full paragraph, we are adding the following language.

“II. Provisions of the Final Rule and Analysis of and Responses to Public Comments for PFS

A. Background

Since January 1, 1992, Medicare has paid for physicians’ services under section 1848 of the Act, “Payment for Physicians’ Services.” The PFS relies on national relative values that are established for work, practice expense (PE), and malpractice (MP), which are adjusted for geographic cost variations. These values are multiplied by a conversion factor (CF) to convert the relative value units (RVUs) into payment rates. The concepts and methodology underlying the PFS were enacted as part of the Omnibus Budget Reconciliation Act of 1989 (Pub. L. 101-239, enacted on December 19, 1989) (OBRA ’89), and the Omnibus Budget Reconciliation Act of 1990 (Pub. L. 101-508, enacted on November 5, 1990) (OBRA ’90). The final rule

published on November 25, 1991 (56 FR 59502) set forth the first fee schedule used for payment for physicians' services.

We note that throughout this major final rule, unless otherwise noted, the term "practitioner" is used to describe both physicians and nonphysician practitioners (NPPs) who are permitted to bill Medicare under the PFS for the services they furnish to Medicare beneficiaries.

1. Development of the Relative Values

a. Work RVUs

The work RVUs established for the initial fee schedule, which was implemented on January 1, 1992, were developed with extensive input from the physician community. A research team at the Harvard School of Public Health developed the original work RVUs for most codes under a cooperative agreement with the Department of Health and Human Services (HHS). In constructing the code-specific vignettes used in determining the original physician work RVUs, Harvard worked with panels of experts, both inside and outside the federal government, and obtained input from numerous physician specialty groups.

As specified in section 1848(c)(1)(A) of the Act, the work component of physicians' services means the portion of the resources used in furnishing the service that reflects physician time and intensity. We establish work RVUs for new, revised and potentially misvalued codes based on our review of information that generally includes, but is not limited to, recommendations received from the American Medical Association/Specialty Society Relative Value Scale Update Committee (RUC), the Health Care Professionals Advisory Committee (HCPAC), the Medicare

Payment Advisory Commission (MedPAC), and other public commenters; medical literature and comparative databases; as well as a comparison of the work for other codes within the Medicare PFS, and consultation with other physicians and health care professionals within CMS and the federal government. We also assess the methodology and data used to develop the recommendations submitted to us by the RUC and other public commenters, and the rationale for their recommendations. In the CY 2011 PFS final rule with comment period (75 FR 73328 through 73329), we discussed a variety of methodologies and approaches used to develop work RVUs, including survey data, building blocks, crosswalk to key reference or similar codes, and magnitude estimation. More information on these issues is available in that rule.

b. Practice Expense RVUs

Initially, only the work RVUs were resource-based, and the PE and MP RVUs were based on average allowable charges. Section 121 of the Social Security Act Amendments of 1994 (Pub. L. 103-432, enacted on October 31, 1994), amended section 1848(c)(2)(C)(ii) of the Act and required us to develop resource-based PE RVUs for each physicians' service beginning in 1998. We were required to consider general categories of expenses (such as office rent and wages of personnel, but excluding MP expenses) comprising PEs. The PE RVUs continue to represent the portion of these resources involved in furnishing PFS services.

Originally, the resource-based method was to be used beginning in 1998, but section 4505(a) of the Balanced Budget Act of 1997 (Pub. L. 105-33, enacted on August 5, 1997) (BBA) delayed implementation of the resource-based PE RVU system until January 1, 1999. In addition, section 4505(b) of the BBA provided for a

4-year transition period from the charge-based PE RVUs to the resource-based PE RVUs.

We established the resource-based PE RVUs for each physicians' service in the November 2, 1998 final rule (63 FR 58814), effective for services furnished in CY 1999. Based on the requirement to transition to a resource-based system for PE over a 4-year period, payment rates were not fully based upon resource-based PE RVUs until CY 2002. This resource-based system was based on two significant sources of actual PE data: the Clinical Practice Expert Panel (CPEP) data; and the AMA's Socioeconomic Monitoring System (SMS) data. These data sources are described in greater detail in the CY 2012 PFS final rule with comment period (76 FR 73033).

Separate PE RVUs are established for services furnished in facility settings, such as a hospital outpatient department (HOPD) or an ambulatory surgical center (ASC), and in nonfacility settings, such as a physician's office. The nonfacility RVUs reflect all of the direct and indirect PEs involved in furnishing a service described by a particular HCPCS code. The difference, if any, in these PE RVUs generally results in a higher payment in the nonfacility setting because in the facility settings some costs are borne by the facility. Medicare's payment to the facility (such as the outpatient prospective payment system (OPPS) payment to the HOPD) would reflect costs typically incurred by the facility. Thus, payment associated with those facility resources is not made under the PFS.

Section 212 of the Balanced Budget Refinement Act of 1999 (Pub. L. 106-113, enacted on November 29, 1999) (BBRA) directed the Secretary of

Health and Human Services (the Secretary) to establish a process under which we accept and use, to the maximum extent practicable and consistent with sound data practices, data collected or developed by entities and organizations to supplement the data we normally collect in determining the PE component. On May 3, 2000, we published the interim final rule (65 FR 25664) that set forth the criteria for the submission of these supplemental PE survey data. The criteria were modified in response to comments received, and published in the **Federal Register** (65 FR 65376) as part of a November 1, 2000 final rule. The PFS final rules published in 2001 and 2003, respectively, (66 FR 55246 and 68 FR 63196) extended the period during which we would accept these supplemental data through March 1, 2005.

In the CY 2007 PFS final rule with comment period (71 FR 69624), we revised the methodology for calculating direct PE RVUs from the top-down to the bottom-up methodology beginning in CY 2007. We adopted a 4-year transition to the new PE RVUs. This transition was completed for CY 2010. In the CY 2010 PFS final rule with comment period, we updated the practice expense per hour (PE/HR) data that are used in the calculation of PE RVUs for most specialties (74 FR 61749). In CY 2010, we began a 4-year transition to the new PE RVUs using the updated PE/HR data, which was completed for CY 2013.

c. Malpractice RVUs

Section 4505(f) of the BBA amended section 1848(c) of the Act to require that we implement resource-based MP RVUs for services furnished on or after CY 2000. The resource-based MP RVUs were implemented in the PFS final rule

with comment period published November 2, 1999 (64 FR 59380). The MP RVUs are based on commercial and physician-owned insurers' MP insurance premium data from all the states, the District of Columbia, and Puerto Rico. For more information on MP RVUs, see section II.C. of this final rule.

d. Refinements to the RVUs

Section 1848(c)(2)(B)(i) of the Act requires that we review RVUs no less often than every 5 years. Prior to CY 2013, we conducted periodic reviews of work RVUs and PE RVUs independently. We completed 5-year reviews of work RVUs that were effective for calendar years 1997, 2002, 2007, and 2012.

Although refinements to the direct PE inputs initially relied heavily on input from the RUC Practice Expense Advisory Committee (PEAC), the shifts to the bottom-up PE methodology in CY 2007 and to the use of the updated PE/HR data in CY 2010 have resulted in significant refinements to the PE RVUs in recent years.

In the CY 2012 PFS final rule with comment period (76 FR 73057), we finalized a proposal to consolidate reviews of work and PE RVUs under section 1848(c)(2)(B) of the Act and reviews of potentially misvalued codes under section 1848(c)(2)(K) of the Act into one annual process.

In addition to the 5-year reviews, beginning for CY 2009, CMS and the RUC identified and reviewed a number of potentially misvalued codes on an annual basis based on various identification screens. This annual review of work and PE RVUs for potentially misvalued codes was supplemented by the amendments to section 1848 of the Act, as enacted by section 3134 of the Affordable Care Act, that require the agency to periodically identify, review and adjust values for potentially

misvalued codes.

e. Application of Budget Neutrality to Adjustments of RVUs

As described in section VII. of this final rule, in accordance with section 1848(c)(2)(B)(ii)(II) of the Act, if revisions to the RVUs cause expenditures for the year to change by more than \$20 million, we make adjustments to ensure that expenditures do not increase or decrease by more than \$20 million.

2. Calculation of Payments Based on RVUs

To calculate the payment for each service, the components of the fee schedule (work, PE, and MP RVUs) are adjusted by geographic practice cost indices (GPCIs) to reflect the variations in the costs of furnishing the services. The GPCIs reflect the relative costs of work, PE, and MP in an area compared to the national average costs for each component. Please refer to the CY 2017 PFS final rule with comment period for a discussion of the last GPCI update (81 FR 80261 through 80270).

RVUs are converted to dollar amounts through the application of a CF, which is calculated based on a statutory formula by CMS's Office of the Actuary (OACT). The formula for calculating the Medicare PFS payment amount for a given service and fee schedule area can be expressed as:

$$\text{Payment} = [(\text{RVU work} \times \text{GPCI work}) + (\text{RVU PE} \times \text{GPCI PE}) + (\text{RVU MP} \times \text{GPCI MP})] \times \text{CF}$$

3. Separate Fee Schedule Methodology for Anesthesia Services

Section 1848(b)(2)(B) of the Act specifies that the fee schedule amounts for anesthesia services are to be based on a uniform relative value guide, with

appropriate adjustment of an anesthesia CF, in a manner to ensure that fee schedule amounts for anesthesia services are consistent with those for other services of comparable value. Therefore, there is a separate fee schedule methodology for anesthesia services. Specifically, we establish a separate CF for anesthesia services and we utilize the uniform relative value guide, or base units, as well as time units, to calculate the fee schedule amounts for anesthesia services. Since anesthesia services are not valued using RVUs, a separate methodology for locality adjustments is also necessary. This involves an adjustment to the national anesthesia CF for each payment locality.”

2. On page 59575, column 3, 3rd full paragraph we are removing the sentence, “We note that CPT code 99457 describes professional time and therefore cannot be furnished by auxiliary personnel incident to a practitioner’s professional services.” and adding in its place, “We thank commenters and confirm that these services may be furnished by auxiliary personnel incident to a practitioner’s professional service.”

3. On page 60070, in the 3rd column; in the first full paragraph, in the section heading, 3. Outpatient Therapy Services; line 1, we are correcting the section reference in the sentence, “As noted in section II.M. of this final rule,” to read “As noted in section II.L. of this final rule,”.

Dated: March 5, 2019.

Ann C. Agnew,

Executive Secretary to the Department,

Department of Health and Human

Services.

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