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CY 2020 PHYSICIAN FEE SCHEDULE PROPOSED RULE SUMMARY

On July 29, the Center for Medicare and Medicaid Services (CMS) released the proposed Medicare Physician Fee Schedule (MPFS) rule for 2020. This proposal updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found here.

The proposal is currently open for comment through September 27. The rule's provisions, if finalized, will be effective January 1, 2020 unless stated otherwise. The following summarizes the major policies in the proposal, excluding the provisions of the rule related to the new long term EEG monitoring codes, which can be found here.

Conversion Factor and Specialty Impact

The proposed conversion factor for 2020 is $36.0896, an increase of only 5 cents from 2019. Table 110 (see Appendix A), extracted from the rule, provides a summary of the impact of the changes in the proposed 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 proposed rule shows changes in the range of minus 4 percent to plus 3 percent with hematology experiencing a 0% change in 2020.

Attached to this summary is a chart showing the proposed changes in relative values (RVUs) and payment rates in 2020 for services provided by hematologists/oncologists. In general, the values for these services in 2020 remain stable, with little fluctuation.

Payment for Evaluation and Management Visits

For CY 2021, CMS is proposing significant improvements to the documentation and payment of outpatient evaluation and management (E/M) services. Last year, the agency had created a single, blended payment rate for level 2 through 4 visits with simplified documentation requirements. In this year's proposed rule, CMS proposes to implement the revised E/M code definitions developed by the AMA CPT Editorial Panel and not implement the consolidation of E/M codes as previously planned.

CMS estimates the specialty level impact of these E/M changes should they be implemented in CY 2021. They can be found in Appendix B of this summary, which includes Table 111 extracted from the rule. According to CMS the impact of the E/M revisions in 2020 will result in a 12% increase for hematology/oncology. A detailed description of the E/M policies proposed in this rule for implementation in 2021 follows:

E/M PAYMENT: CMS proposes to retain separate payment for the individual E/M services as revised by the CPT Editorial Panel. This includes the elimination of CPT code 99201. CMS proposes to adopt all of the RUC-recommended work RVUs and times for the revised code family and the new prolonged add-on code that were based on a survey of over 50 specialty societies. CMS believes these values more accurately account for the time and intensity of these services than the policy finalized in last year's rule.

E/M Payment Comparison			
Visit Level	**Current Payment***	**Proposed Work RVUs**	**Proposed Payment****
99201	$45	N/A – Code would be eliminated	N/A – Code would be eliminated
99202	$76	0.93	$77
99203	$110	1.60	$119
99204	$167	2.60	$177
99205	$211	3.50	$232
99211	$22	0.18	$24
99212	$45	0.70	$60
99213	$74	1.30	$96
99214	$109	1.92	$136
99215	$148	2.80	$190
99XXX (New prolonged service)	N/A	0.61	$34.60
GPC1X (New Complexity Add-on)	N/A	0.33	$18.02

**Current payment for CY 2019*
*** Proposed payment based on the proposed relative value units and the CY 2019 payment rates.*

DOCUMENTATION: CMS is proposing to implement the documentation requirements that were included in the CPT Editorial Panel's revisions to the code set in 2021. This will allow physicians to select a code level based on time or medical decision-making and eliminate the history and physical exam as required elements to select a code level. Documentation of these elements must be specific to each code level. Detailed information about the documentation requirements can be found here.

PROLONGED SERVICE: CMS is proposing to pay separately for prolonged outpatient E/M services using the new CPT add-on code 99XXX and delete GPRO1 that had been finalized last year for such services. CMS proposes that this code only be available when physicians choose to document based on time and the time for a level 5 visit is exceeded by 15 minutes or more on the date of service. This service could be billed multiple times for each additional 15-minute increment beyond the level 5 visit time. The agency proposes to adopt the RUC-recommended work RVU for this service.

COMPLEXITY ADD-ON CODE: CMS does not believe that the revised code set adequately describes or reflects the resources required for primary care and certain types of specialty care and continues to believe there is a need to capture these additional resource costs with an add-on code. In this rule, the agency is proposing to establish a single add-on code with a revised descriptor to describe the work associated with ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. The descriptor for the new add-on code (GPC1X) has been revised as follows:

> *Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex condition.*

CMS is proposing a work RVU of 0.33 and physician time of 11 minutes and will allow the code to be billed with any level outpatient E/M service.

Care Management Services

Besides addressing the outpatient E/M code valuations and documentation requirements, CMS separately addresses care management services, those codes designed to improve care management and coordination. The agency outlines policies to improve the existing transitional care management (TCM), chronic care management (CCM) and chronic care remote physiologic monitoring (RPM) services. The agency also proposes new codes for principal care management (PCM) services, which are for the care management of patients having a single, serious, or complex chronic condition.

Transitional Care Management Services: TCM services are designed to capture the care required to manage a patient's transition from an inpatient hospital setting to a community setting. It covers the care delivered in the 30-day period that begins on the patient's discharge date. CMS believes that increasing the utilization of TCM services may improve patient outcomes. Therefore, the agency is proposing to revise the billing requirements for TCM services to allow 14 codes previously prohibited from being billed concurrently with TCM to be separately billed and reimbursed. See Table 17 extracted from the rule below for this list of services. The agency now believes that these codes complement TCM services rather than substantially overlapping with them.

TABLE 17: 14 HCPCS Codes that Currently Cannot be Billed Concurrently with TCM by the Same Practitioner and are Active Codes Payable by Medicare PFS

Code Family	HCPCS Code	Descriptor
Prolonged Services without Direct Patient Contact	99358	Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service
	99359	Prolonged E/M service before and/or after direct patient care; each additional 30 minutes beyond the first hour of prolonged services
Home and Outpatient International Normalized Ratio (INR) Monitoring Services	93792	Patient/caregiver training for initiation of home INR monitoring
	93793	Anticoagulant management for a patient taking warfarin; includes review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment and scheduling of additional test(s)
Interpretation of Physiological Data	99091	Collection & interpretation of physiologic data, requiring a minimum of 30 minutes each 30 days
Complex Chronic Care Management Services	99487	Complex Chronic Care with 60 minutes of clinical staff time per calendar month
	99489	Complex Chronic Care; additional 30 minutes of clinical staff time per month
Care Plan Oversight Services	G0181	Physician supervision of a patient receiving Medicare-covered services provided by a

		participating home health agency (patient not present) requiring complex and multidisciplinary care modalities within a calendar month; 30+ minutes
	G0182	Physician supervision of a patient receiving Medicare-covered hospice services (Pt not present) requiring complex and multidisciplinary care modalities; within a calendar month; 30+ minutes

Chronic Care Management (CCM) Services: CCM services are comprehensive care coordination services furnished by a physician or non-physician practitioner (NPP) and their clinical staff for managing the overall care of a patient with two or more serious chronic conditions. These services can be billed once per calendar month. Currently, there are two subsets of codes: one for non-complex chronic care management and one for chronic care management.

Non-Complex CCM Services by Clinical Staff (CPT code 99490, HCPCS code GCCC1 and GCCC2) - There is currently one CPT code for non-complex CCM, CPT code 99490 which describes 20 or more minutes of clinical staff time spent in chronic care management. CMS is proposing two new G-codes with new increments of clinical staff time that can be billed with CPT code 99490.

- GCCC1 describes the initial 20 minutes of clinical staff time and is proposed to have 0.61 work RVU.
- GCCC2 describes each additional 20 minutes and is proposed to have 0.54 work RVU.

Complex CCM Services (CPT codes 99487 and 99489, HCPCS Codes GCCC3 and GCCC4) - The complex CCM services describe care management for patients whose care requires both clinical staff time and complex medical decision-making. The current CPT codes 99487 and 99489 include a requirement to establish or substantially revise a comprehensive care plan. CMS is proposing to adopt two new G-codes in place of the existing CPT codes because the agency does not believe it is necessary to include substantial care plan revision as a component of these services. These G-codes would remain in place until the CPT Editorial panel is able to revise the existing codes.

CMS is proposing to simplify the definition of, and requirements for a typical care plan as included in CCM services (Current service requirements can be found online here.) and requests comment on the revised definition.

Principal Care Management Services: CMS is proposing to create this new service to recognize care management services for patients with only one chronic condition that would be provided by a physician or clinical staff under the direction of a physician or other qualified healthcare provider. There are no specialty restrictions on these new services and they would be available to providers who are managing a patient's total care over a calendar month. A qualifying condition would typically be expected to last between three months and a year, or until the death of a patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. To bill a PCM service, CMS is proposing that providers document the patient's verbal consent to the service in the medical record as is required for CCM services.

CMS is proposing to adopt two new G-codes to describe these services: GPPP1 and GPPP2

- GPPP1 (1.28 RVUs proposed) describes at least 30 minutes of care in a calendar month provided by a physician or other qualified health care professional. This service is for a single high-risk disease and includes the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.
- GPPP2 (0.61 RVUs proposed) has the same time requirement over a calendar month and has the same requirements, but is delivered by clinical staff under the direction of a physician or other qualified health care professional.

The agency is seeking public comment on whether it would be appropriate to create an add-on code for additional time spent each month (similar to the proposed GCCC2) when PCM services are furnished by clinical staff under the direction of the billing practitioner.

Reimbursement for Online Digital Evaluation Services (e-Visits)

CMS is proposing to pay for six new non-face-to-face codes to describe the care provided for patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office. These new codes are for established patients only and cover the cumulative time over a seven-day period required to deliver this care. Three of these codes can be billed by non-physician healthcare providers who cannot independently bill these services, and the other three are for physician services. Below find the descriptors and proposed work values of the three physician codes:

- 9X0X1 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes*) – 0.25 work RVU
- 9X0X2 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes*) – 0.50 work RVU
- 9X0X3 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes*) – 0.80 work RVU

Review and Verification of Medical Record Documentation

Last year CMS finalized policy to allow a physician, resident, or nurse to document in the medical record that the teaching physician was present at the time the service was delivered. They also eliminated 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 to allow the resident or nurse to document the extent of the teaching physician's participation.

CMS is now proposing to provide the same relief for non-physician practitioners authorized to deliver Part B services, including NPs, CNSs, CNMs and PAs. If finalized, the furnishing practitioner will be able to review and verify, rather than re-document, information included in the medical record by these students. The agency seeks comments on this proposal.

Open Payments Program
The Open Payments program was established to increase transparency by providing information about financial relationships between pharmaceutical and medical device industry and other types of health care providers. Specifically, the program requires manufactures of covered drugs, devices, biologicals, or medical supplies to annually submit information for the preceding calendar year about certain payments or other transfers of value made to "covered recipients." Examples of payments or other transfers of value that must be reported include research, honoraria, gifts, travel expenses, meals, grants, and other compensation.

CMS is proposing to expand the definition of a covered recipient, which currently includes physicians and teaching hospitals to be consistent with Section 6111 of the SUPPORT Act to also include "mid-level practitioners," including PAs, NPs, CNSs, CRNAs, and CNMs beginning January 1, 2022.

When reporting payments, applicable manufacturers and applicable GPOs must select the "Nature of Payment" category that most accurately represents the reported payment. CMS proposes to revise these categories by consolidating two duplicative categories for continuing education programs and modify the name to match the statutory language, "medical education programs."

CMS also proposes to add three new "Nature of Payment" categories: debt forgiveness, long-term medical supply or device loan, and acquisitions. The agency also is proposing to require manufactures and applicable group purchasing organizations (GPOs) to provide the device identifiers (DIs) in Open Payments reporting to enhance the usefulness of Open Payments data and provide more precise information about the medical supplies and devices associated with a transaction.

CMS proposes that the above changes become effective for data collection beginning in CY 2021 and reported in CY 2022.

Physician Supervision for Physician Assistant (PA) Services
Currently, the supervision requirement for PAs requires their services to be delivered under a physician's overall direction and control, but the physician's presence is not required during the performance of these services. CMS proposes to revise the physician supervision requirement for PA services under Medicare. Specifically, CMS proposes to grant PAs the flexibility to practice in accordance with state law requirements rather than the current general supervision requirement. In the absence of a state law, CMS proposes that the physician supervision requirement be met by "documentation in the medical record of the PA's approach to working with physicians in furnishing their services."

Quality Payment Program (QPP)/Merit-Based Incentive Payment System (MIPS) Provisions
A high-level summary of the proposed changes to the QPP follow. A more detailed summary will be provided separately.

Request for Information on a new MIPS Value Pathways initiative
CMS proposes a new MIPS Value Pathways (MVP) framework that would connect measures and activities across the 4 MIPS performance categories (Quality, Cost, Improvement Activities and Promoting Interoperability) to be implemented in 2021. MVP would incorporate a set of administrative claims-based quality measures that focus on population health, provide data and feedback to clinicians, and enhance information provided to patients.

By 2021, CMS proposes to move from reporting on activities under the four performance categories under MIPS and transition to the new MVP framework with a unified set of measures centered on a specific condition or specialty. Under the MVP framework, clinicians would report on a smaller set of measures that are outcomes-based, specialty-specific and more closely aligned with the Advanced APMs. The agency specifically requested comment on four key issues relating to the development of MVPs*:*

- How to construct MVPs, including approach, definition, development, specification, and examples;
- How to solicit measures and activities for MVPs;
- How to determine MVP assignment, for clinicians and for multispecialty groups; and
- How to transition to MVPs.

In the proposed rule, CMS provides four examples to illustrate the construction and assignment of measures and activities for MVPs. Two examples for primary care/general medicine include preventive health and diabetes prevention and treatment. For procedural specialties, the examples are for major surgery and general ophthalmology. Each example presents no more than four quality or cost measures or improvement activities for each performance category, and prioritized outcome and patient reported measures, non-topped out measures, and eCQMs. Population health measures and the measures in the Promoting interoperability performance category would also apply to all MVPs. The agency requests feedback on the examples of possible MVPs, as well as options to promote interoperability.

MIPS Measures

Each year CMS proposes changes to the MIPS measures set. The changes below apply to Hematologists.

Proposed MIPS Quality Measures for 2022 MIPS Payment Year and Future Payment Years - All-Cause Unplanned Admission for Patients with Multiple Chronic Diseases

Proposed Changes to Specialty Measure Sets for 2022 MIPS Payment Year and Future Payment Years

Oncology/Hematology—Proposed Addition		
Measure Title and Description	**Measure Type/Domain**	**Measure Steward**
Hematology: MDS and Acute Leukemia: Baseline Cytogenetic Testing Performed in Bone Marrow	Process/Effective Clinical Care	ASH
Hematology: Multiple Myeloma Treatment with Bisphosphonates	Process/Effective Clinical Care	ASH
Hematology: CLL: Baseline Flow Cytometry	Process/Effective Clinical Care	PCPI
Adult Vaccination Status	Process/Community + Population Health	NCQA

APPENDIX A

TABLE 110: CY 2020 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***
ALLERGY/IMMUNOLOGY	$236	0%	0%	0%	0%
ANESTHESIOLOGY	$1,993	0%	0%	0%	0%
AUDIOLOGIST	$70	0%	0%	0%	1%
CARDIAC SURGERY	$279	-1%	-1%	0%	-1%
CARDIOLOGY	$6,595	0%	0%	0%	0%
CHIROPRACTOR	$750	0%	0%	-1%	-1%
CLINICAL PSYCHOLOGIST	$787	1%	2%	0%	3%
CLINICAL SOCIAL WORKER	$781	0%	3%	0%	3%
COLON AND RECTAL SURGERY	$162	0%	1%	0%	1%
CRITICAL CARE	$346	0%	0%	0%	1%
DERMATOLOGY	$3,541	0%	1%	-1%	0%
DIAGNOSTIC TESTING FACILITY	$697	0%	-2%	0%	-2%
EMERGENCY MEDICINE	$3,021	1%	0%	1%	1%
ENDOCRINOLOGY	$488	0%	0%	0%	0%
FAMILY PRACTICE	$6,019	0%	0%	0%	0%
GASTROENTEROLOGY	$1,713	0%	0%	-1%	-1%
GENERAL PRACTICE	$405	0%	0%	0%	0%
GENERAL SURGERY	$2,031	0%	0%	0%	0%
GERIATRICS	$187	0%	0%	0%	0%
HAND SURGERY	$226	0%	0%	0%	1%
HEMATOLOGY/ONCOLOGY	$1,673	0%	0%	0%	0%
INDEPENDENT LABORATORY	$592	0%	1%	0%	1%
INFECTIOUS DISEASE	$640	0%	0%	0%	0%
INTERNAL MEDICINE	$10,507	0%	0%	0%	0%
INTERVENTIONAL PAIN MGMT	$885	0%	0%	0%	1%
INTERVENTIONAL RADIOLOGY	$432	0%	-2%	0%	-2%
MULTISPECIALTY CLINIC/OTHER PHYS	$148	0%	0%	0%	0%
NEPHROLOGY	$2,164	0%	0%	0%	1%
NEUROLOGY	$1,503	-1%	3%	0%	2%
NEUROSURGERY	$802	0%	0%	-1%	-1%

NUCLEAR MEDICINE	$50	0%	1%	0%	1%
NURSE ANES / ANES ASST	$1,291	0%	0%	0%	0%
NURSE PRACTITIONER	$4,503	0%	0%	0%	0%
OBSTETRICS/GYNECOLOGY	$620	0%	1%	0%	1%
OPHTHALMOLOGY	$5,398	-2%	-3%	0%	-4%
OPTOMETRY	$1,325	0%	-1%	0%	-2%
ORAL/MAXILLOFACIAL SURGERY	$71	0%	0%	-1%	-2%
ORTHOPEDIC SURGERY	$3,734	0%	0%	0%	1%
OTHER	$34	0%	0%	0%	1%
OTOLARNGOLOGY	$1,225	0%	0%	0%	0%
PATHOLOGY	$1,203	0%	0%	0%	0%
PEDIATRICS	$62	0%	0%	0%	0%
PHYSICAL MEDICINE	$1,110	0%	0%	0%	0%
PHYSICAL/OCCUPATIONAL THERAPY	$4,248	0%	0%	0%	0%
PHYSICIAN ASSISTANT	$2,637	0%	0%	0%	0%
PLASTIC SURGERY	$369	0%	0%	0%	0%
PODIATRY	$1,998	0%	1%	0%	1%
PORTABLE X-RAY SUPPLIER	$94	0%	0%	0%	0%
PSYCHIATRY	$1,120	0%	0%	0%	1%
PULMONARY DISEASE	$1,658	0%	0%	0%	0%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	$1,756	0%	0%	0%	0%
RADIOLOGY	$4,971	0%	0%	0%	-1%
RHEUMATOLOGY	$534	0%	0%	0%	0%
THORACIC SURGERY	$352	-1%	0%	0%	-1%
UROLOGY	$1,739	0%	1%	0%	1%
VASCULAR SURGERY	$1,203	0%	-2%	0%	-2%
TOTAL	**$92,979**	**0%**	**0%**	**0%**	**0%**
* Column F may not equal the sum of columns C, D, and E due to rounding.					

APPENDIX B

TABLE 111: CY 2020 PFS Estimated Specialty Level Impacts of Proposed E/M Payment and Coding Policies if Implemented for CY 2021					
(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***
ALLERGY/IMMUNOLOGY	$236	4%	3%	0%	7%
ANESTHESIOLOGY	$1,993	-5%	-1%	0%	-7%
AUDIOLOGIST	$70	-4%	-2%	0%	-6%
CARDIAC SURGERY	$279	-5%	-2%	-1%	-8%
CARDIOLOGY	$6,595	2%	1%	0%	3%
CHIROPRACTOR	$750	-5%	-3%	-1%	-9%
CLINICAL PSYCHOLOGIST	$787	-7%	0%	0%	-7%
CLINICAL SOCIAL WORKER	$781	-7%	0%	0%	-6%
COLON AND RECTAL SURGERY	$162	-3%	-1%	-1%	-4%
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EMERGENCY MEDICINE	$3,021	-6%	-2%	1%	-7%
ENDOCRINOLOGY	$488	11%	5%	1%	16%
FAMILY PRACTICE	$6,019	8%	4%	1%	12%
GASTROENTEROLOGY	$1,713	-2%	-1%	-1%	-4%
GENERAL PRACTICE	$405	5%	2%	0%	8%
GENERAL SURGERY	$2,031	-3%	-1%	0%	-4%
GERIATRICS	$187	2%	1%	0%	3%
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PSYCHIATRY	$1,120	4%	3%	0%	7%
PULMONARY DISEASE	$1,658	0%	1%	0%	1%
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RADIOLOGY	$4,971	-5%	-3%	0%	-8%
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VASCULAR SURGERY	$1,203	-2%	-3%	0%	-5%
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