CMS Releases Medicare Physician Fee Schedule Final Rule for 2020

On November 1, 2019, the Centers for Medicare & Medicaid Services (CMS) published the Medicare Physician Fee Schedule Final Rule for calendar year (CY) 2020. The final rule updates payment rates and policy changes for services effective on or after January 1, 2020. The final rule also includes updates for the Quality Payment Program (QPP). The final rule will be published in the *Federal Register* on November 15, 2019.

It is important to note that any changes to the fee schedule must be budget-neutral. This means that an upward adjustment in payment for an existing or new code requires an offset or downward adjustment in another area. The following summary includes policy changes and updates to payment rates under the CY 2020 rule, including decreases, increases, and newly established codes.

Key Payment Policy Provisions in the Final Rule

Conversion Factor

The CY 2020 Physician Fee Schedule conversion factor is $36.09, a slight increase by only five cents from the current conversion factor of $36.04. The anesthesia conversion factor will decrease from $22.27 to $22.20 for CY 2020. CMS applied a 0.14 percent budget neutrality adjustment to both conversion factors, and an additional -0.46 percent practice expense and malpractice adjustment to the anesthesia conversion factor. There was no statutorily required conversion factor update for CY 2020, as the updates mandated by the Medicare Access and CHIP Reauthorization Act (MACRA) of 2015 and the Balanced Budget Act of 2018 expired in 2019.

Final Estimated Specialty RVU Impacts

Final updates to physician work, practice expense and malpractice RVUs for CY 2020 will result in positive changes in total allowed charges for several specialties. The table below shows the estimated combined RVU impacts of the final Evaluation and Management (E/M) payment and coding policies for some specialties. Other policy changes finalized for CY 2020 are not reflected in the table. Overall, specialties that bill a high number of E/M visits can expect to see the greatest increases, whereas specialties that do not generally bill E/M visits will likely experience decreases in payment. The actual impact will vary depending on geographic location and the mix of services provided in a practice. The entire estimated specialty level impacts are listed in Table 120 of the final rule.

Estimated Specialty Level Impacts of Finalized E/M Payment and Coding Policies			
Endocrinology	16%	Ophthalmology	-10%
Rheumatology	15%	Chiropractor	-9%
Family Practice	12%	Nurse Anesthetists	-9%
Hematology/Oncology	12%	Cardiac Surgery	-8%
General Practice	8%	Pathology	-8%
Neurology	8%	Physical/Occupational Therapy	-8%
Urology	8%	Radiology	-8%
Obstetrics/Gynecology	7%	Emergency Medicine	-7%
Psychiatry	7%	Thoracic Surgery	-7%
Pediatrics	6%	Anesthesiology	-7%
Internal Medicine	4%	General Surgery	-4%

Source: CY 2020 Medicare Physician Fee Schedule Final Rule, Table 120

Evaluation & Management Visits

CMS finalized its proposal to overhaul the coding, payment and documentation guidelines for office/outpatient E/M visits (CPT codes 99202-99205 and 99211-99215) confirmed in the CY 2019 final rule for CY 2021. The AOA worked closely with the CPT Editorial Panel and the RUC to develop the new coding framework and payment rates. Starting January 1, 2021, the following changes will take effect:

- Eliminate uniform payment rates for E/M levels two – four. In CY 2019, CMS finalized a policy to blend payment rates. Starting in CY 2021, CMS will pay for each level of service separately, and adopt revised work and practice expense inputs.

- Retain five E/M levels for established patients (99211-99215) and reduce the E/M levels from five to four for new patients (99202 – 99205). E/M visit 99201 will be deleted since the level of medical decision making (MDM) for 99201 and 99202 are both straightforward and only differ by history and exam.

- Allow clinicians to choose E/M visits based on MDM or total time (including face-to-face and non-face-to-face time). The history and/or exam for E/M code selection will only be required when medically necessary.

- Adopt a new add-on CPT code (99XXX) for prolonged office/outpatient E/M visits and eliminate GPRO1 previously finalized for CY 2021. The new code will be used to report time spent on the date of service for a level five office/outpatient E/M visit (99205 or 99215) that exceeds 15 minutes or more. Starting CY 2021, CPT codes 99358-99359 (Prolonged E/M without Direct Patient Contact) will not be reportable with office/outpatient E/M visits.

- Consolidate the previously finalized add-on CPT codes for complex or chronic primary care and specialty cases into a single code (GPC1X), billable with all office/outpatient E/M visits.

The following table illustrates the new work RVUs and times for office/outpatient E/M visits.

CPT Code	CY 2019 Work RVUs	Previously Finalized CY 2021 Work RVUs	New CY 2021 Work RVUs	New CY 2021 Times
New Patient Office/Outpatient E/M Visit				
99201	0.48	0.48	N/A	N/A
99202	0.93	1.76	0.93	15-29 minutes
99203	1.42	1.76	1.60	30-44 minutes
99204	2.43	1.76	2.60	45-59 minutes
99205	3.17	3.17	3.50	60-74 minutes
Established Patient Office/Outpatient E/M Visit				
99211	0.18	0.18	0.18	7 minutes
99212	0.48	1.18	0.70	10-19 minutes
99213	0.97	1.18	1.30	20-29 minutes
99214	1.50	1.18	1.92	30-39 minutes
99215	2.11	2.11	2.80	40-54 minutes
Prolonged Service Add-On Code				
99XXX	N/A	1.17	0.61	≥ 55 minutes
Complex or Chronic Condition Add-On Code				
GPC1X	N/A	0.25	0.33	11 minutes

Assistance to help members understand the new guidelines and code revisions will be provided through the American Osteopathic Information Association (AOIA) Physician Services Department in the coming weeks. More information on the E/M revisions and a copy of the E/M MDM grid are available on the American Medical Association website.

For CY 2020, physicians may continue to use either the "1995" or "1997" E/M Documentation Guidelines for coding and billing office/outpatient E/M visits to Medicare.

Global Periods
CMS did not adopt the RUC's recommendation to align the valuation of procedures with 10- or 90-day global periods with the valuation of stand-alone office/outpatient E/M visits effective CY 2021.

Transitional Care Management (TCM)
CMS finalized its proposal to adopt RUC-recommended work RVUs and practice expense refinements to increase payment for TCM services. For CY 2020, CPT code 99495 will have a work RVU of 2.36 increased from the current work RVU of 2.11, and CPT code 99496 will have a work RVU of 3.10 up from the current work RVU of 3.05. The AOA played an active role in securing the increased TCM values. CMS will also allow concurrent billing of 14 other care management codes (Table 20) currently restricted from billing with TCM services.

Chronic Care Management (CCM)
CMS did not finalize its proposal to create two new temporary HCPCS codes for CCM services, but did create a new add-on HCPCS code (G2058) to allow a physician or other qualified health care professional to report CCM services in 20 minute increments that extend beyond the time of the initial CCM code. G2058 will have a work RVU of 0.54 for CY 2020.

Principle Care Management (PCM)
As proposed, CMS created two new PCM services to allow separate payment for management of patients with only one serious chronic condition, furnished by a primary care physician or specialist. The CCM codes require patients to have two or more chronic conditions. HCPCS code G2064 will be assigned a work RVU of 1.45 and be reported monthly when a physician or other qualified health care professional spends at least 30 minutes of time care for a patient with a single high risk disease or complex chronic condition. HCPCS code G2065 will have a work RVU of 0.61 reported monthly when clinical staff spends at least 30 minutes of time on comprehensive management for a single high risk disease or complex chronic condition. A summary of services required for reporting PCM codes can be found in Table 24 of the final rule.

Communication Technology-Based Services
In the CY 2019 final rule, CMS finalized payment for a number of communication-based technology services and inter-professional consultation services (G2010, G2012, 99446-99449, 99451 and 99452). Starting in CY 2020, these services will no longer require physicians to obtain beneficiary consent at the outset for each visit. Instead, CMS will allow for a one-time consent to be obtained on an annual basis.

Physician Supervision for Physician Assistant (PA) Services
CMS finalized its proposal to revise statutory physician supervision requirements for PA services in accordance with state law and state scope of practice rules. In the absence of state law governing medical direction and supervision of PA services, a PA must provide documentation, upon request, evidencing how the PA works with physicians.

Review and Verification of Medical Record Documentation
CMS also finalized its proposal to allow PAs and advanced practice registered nurses (APRN) to review and verify, rather than re-document, notes made in the medical record by other physicians, residents, medical, physician assistant, and APRN students, nurses, or other members of the medical team.

Medicare Coverage for Opioid Use Disorder and Opioid Treatment Programs
In accordance with the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, CMS finalized a separate Medicare Part B benefit category for patients suffering from opioid use disorder (OUD), to include delivery of medication-assisted treatment (MAT) furnished by opioid treatment programs (OTP). In addition, CMS created three new HCPCS codes (G2086, G2087 and G2088) to provide monthly payment for a bundled episode of care including development of a treatment plan, care coordination, individual and group therapy, and counseling for patients with OUD.

Telehealth Services
For CY 2020, CMS will add three new OUD HCPCS codes (G2086, G2087 and G2088) to the list of Medicare covered telehealth services.

Denial or Revocation of Physician Enrollment
As proposed, CMS finalized new authority to deny or revoke a physician's enrollment if previously subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health

care with underlying facts reflecting improper physician or other eligible professional conduct that led to patient harm. CMS excluded required participation in rehabilitation or mental/ behavioral health programs and required abstinence from drugs or alcohol and random drug testing from the type of sanctions or disciplinary actions that could trigger a denial or revocation.

CMS will accept comments on the above-mentioned payment and policy changes until December 31, 2019. AOA staff will continue to review the final rule and provide a separate update on the Quality Payment Program.