
MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.
Date: November 5, 2019
Re: **Summary of the CY 2020 Medicare Physician Fee Schedule Final Rule**

The Centers for Medicare and Medicaid Services (“CMS”) released the calendar year (“CY”) 2020 Revisions to Payment Policies under the Physician Fee Schedule (“PFS”) Final Rule (“Final Rule”) on November 1, 2019. In September 2019, AAHKS submitted comments in response to the PFS Proposed Rule (“Proposed Rule”). The following is a summary of CMS actions in the Final Rule related to those comments.

I. Identifying and Reviewing Potentially Misvalued Services Under PFS

In the Proposed Rule, CMS described the history and criteria used to identify and review potentially misvalued services under the PFS. CMS outlined how it evaluates the public nomination of potentially misvalued codes. For example, CMS cites reviewing documentation from national surveys of work time and intensity from professional and management societies and organizations, peer reviewed medical literature or other reliable data that demonstrate changes in physician work due to technique, knowledge and technology, patient population, site-of- service, length of hospital stay, and work time. This year, CMS proposed the following four CPT/HCPCS Codes as potentially misvalued codes: 10005 (Fna bx w/us gdn 1st les), 10021 (Fna bx w/o img gdn 1st les) 76377 (3d render w/intrp postproces) and G0166 (Extrnl counterpulse, per tx).

AAHKS’s Comment took the opportunity to highlight some of the issues plaguing the potential misvalued code process, specifically as it pertains to its impact on total knee arthroplasty (“TKA”) and total hip arthroplasty (“THA”). AAHKS recommended that when CMS evaluates AMA RVS Update Committee (“RUC”) recommendations regarding nominations, CMS should take into account other factors impacting providers in question, such as overall status of the procedure’s transition to value-based care and other CMS directed initiatives changing practice patterns and demanding greater surgeon attention, focus, and time.

In the Final Rule, CMS did not include CPT codes 10005 and 10021 on the final list of potentially misvalued codes for CY 2020. CMS did not acknowledge AAHKS’s concerns regarding the misvalued codes process or criteria.

II. Office/Outpatient Evaluation and Management (E/M) visit Coding and Documentation

In the Proposed Rule, CMS acknowledged that coding, payment, and documentation requirements for E/M visits are overly burdensome and no longer align with the current practice of medicine. To alleviate and mitigate the burden, CMS proposed collapsing the office based and outpatient E/M payment rates, documentation requirements, and create new add-on codes to better capture the differential resources involved in furnishing certain types of E/M visits.

CMS sought to adopt new coding, prefatory language, and an interpretive guidance framework that has been issued by the American Medical Association (“AMA”); the agency believes it would accomplish greater burden reduction than the policies it finalized last year and would be more intuitive and consistent with the current practice of medicine. Under the new policy, history and exam would no longer select the level of code selection for office/outpatient E/M visits. Rather, for levels 2 through 5 office/ outpatient E/M visits, the code level reported would be decided based on either the level of medical decision making (“MDM”) (as redefined in AMA and Current Procedural Terminology (“CPT”) Editorial Panel guidance framework) or the total time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time).

In the Final Rule, CMS choose to align E/M coding with changes adopted by the AMA and CPT Editorial Panel for office/outpatient E/M visits. The CPT coding changes retain 5 levels of coding for established patients, reduce the number of levels to 4 for office/outpatient E/M visits for new patients, and revise the code definitions. The CPT code changes also revised the times and MDM process for all of the codes, and requires performance of history and exam only as medically appropriate. The CPT code changes also allow clinicians to choose the E/M visit level based on either MDM or time.

III. Office/Outpatient E/M Revaluation

In the Proposed Rule, CMS explained that in April 2019, the AMA RVS Update Committee (“RUC”) provided CMS with results of its review, and recommendations for work RVUs, practice expense inputs, and physician time (number of minutes) for the revised office/outpatient E/M code set. This would include separate payment for five levels of office/outpatient E/M visit CPT codes as revised by the CPT Editorial Panel, resurveyed by the RUC, with minor refinement, including deletion of CPT code 99201 (Level 1 new patient office/outpatient E/M visit) and adoption of the revised CPT code descriptors for CPT codes 99202-99215. At the same time, CMS observed that for some codes, the total of time associated with the three service periods (component) did not match the RUC recommended total time.

CMS asked how it should address the discrepancies in times. AAHKS recommended that CMS use the RUC recommended total time in 2021 as it pertains to recommendations for work RVUS, practice expense inputs, and physician time for the revised office/outpatient E/M code set.

In the Final Rule, CMS adopted the AMA RUC-recommended values that will increase payment for office/outpatient E/M visits. CMS emphasized that the RUC recommendations reflect a robust survey approach by the AMA, including surveying more than 50 specialty types, and demonstrating that office/outpatient E/M visits are generally more complex and require additional resources for most clinicians.

IV. Simplification, Consolidation and Reevaluation of HCPCS Codes GCG0X

In the Proposed Rule, CMS proposed a new add-on code that consolidates the two add-on codes GCG0X (complexity inherent to non-procedural specialty care including hematology/oncology, urology, interventional pain management and etc.) and GPC1X (complexity inherent to primary medical care services that service as a focal point for all needed health care services) into one code. CMS sought to simplify the coding by consolidating the two add-on codes into a single add-on code and revising the single code descriptor to better describe the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition.

In the Final Rule, CMS finalized the code descriptor for GPC1X as proposed and GPC1X will be implemented in CY 2021. These codes were finalized in order to reflect the differential resource costs associated with performing certain types of office/outpatient E/M visits. These codes will only be reportable with office/outpatient E/M level 2 through 4 visits.

V. Valuation of the CPT Code 99xxx (Prolonged Office/Outpatient E/M)

In the Proposed Rule, the RUC recommended a new CPT code to account for prolonged office/outpatient visits. CPT code 99xxx (*Prolonged office or other outpatient evaluation and management services beyond the total time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 mins*) The RUC recommended 15 minutes of physician time and a work RVU of 0.61. CMS proposed to delete the HCPCS add-on code finalized last year and adopt this one.

In the Final Rule, CMS finalized its proposal to adopt CPT code 99XXX to report all prolonged time spent on the date of the primary office/outpatient E/M visit code, which is the 24-hour period for the date of service reported for the primary office/outpatient E/M visit code. As such, CMS finalized deleting the HCPCS add-on code finalized last year, GPRO1 extended office/outpatient E/M time, and adopted the prolonged office code.

VI. Global Surgical Packages

In the Proposed Rule, CMS explained that the AMA RUC recommended adjusting the office/outpatient E/M visits for codes with a global period to reflect the changes made to the values for office/outpatient E/M visits. In 2015, Congress directed CMS to survey and analyze post-operative office visits under the global codes. This summer CMS released three reports of

the survey findings. The survey found that that only 4% of procedures with 10-day global periods had any post-operative visits reported. While 71% of procedures with 90-day global periods had at least one associated post-operative visit, only 39% of the total post-operative visits expected for procedures with 90-day global periods were reported. CMS solicited comments from stakeholders to determine if CMS should use the AMA RUC recommended values in light of these survey findings.

In the Final Rule, CMS did not adopt the RUC recommendation to apply revised values for E/M codes to the global surgery codes. CMS acknowledged the importance of relativity across codes, stating that relativity is an important concept the agency considers heavily when establishing values for services under PFS. CMS highlighted that in the past, the agency adjusted values for global surgery procedures when they updated values for E/M visits because the agency did not have information to suggest that it might not be appropriate to do so.

However, now, CMS states that it cannot ignore the unresolved questions regarding how post-operative visits included in global surgery codes should be valued relative to stand-alone E/M visit analogues. CMS states that if the number of E/M services for global codes is not appropriate, adopting the AMA RUC-recommended values for E/M services in global surgery codes would exacerbate rather than ameliorate any potential relativity issues. Therefore, CMS did not adopt the RUC recommendation to apply revised values for E/M services to the global surgery codes at this time.

VII. Episode-Based Cost Performance Measures for the 2020 Performance Period

In the Proposed Rule, CMS proposed adding 10 newly developed episode-based measures to the cost performance category for the 2020 performance period. The newly developed cost performance measure included Elective Primary Hip Arthroplasty. AAHKS supported the development of the Elective Primary Hip Arthroplasty as a procedural measure. In the Final Rule, CMS finalized Elective Primary Hip Arthroplasty for the 2020 performance period and beyond.

VIII. MIPS Value Pathways (MVP) – Request for Information

In the Proposed Rule, CMS proposed a new MVP framework beginning with the 2021 MIPS performance period/2023 MIPS payment year to simplify MIPS, improve value, reduce burden, help patients compare clinician performance, and better inform patient choice in selecting clinicians. CMS solicited comments about the framework.

In the Final Rule, CMS chose to finalize a modified proposal to define MVPs as a subset of measures and activities established through future rulemaking. CMS intends to work with stakeholders to develop MVPs that account for variation in specialty, size, and composition of clinician practices. CMS hopes that MVPs would allow for a more cohesive participation experience by connecting activities and measures from the 4 MIPS performance categories that are relevant to a patient population, a specialty or a medical condition, reducing the siloed nature

of the current MIPS participation experience. CMS has not made any proposals regarding whether participation in MVPs will be mandatory or optional.

Further, CMS emphasized that they received 2,100 comments related to implementation of MVPs. CMS did not summarize and respond to comments they received in this final rule, CMS thanked the commenters for their responses and may take them into account as they develop future policies for the MVPs. CMS is also interested in engaging with stakeholders on additional ways to reduce burden in the MIPS program, in addition to the solicited comment for MVPs.

Moreover, CMS finalized the proposal to strengthen the Qualified Clinical Data Registry (QCDR) measure standards for MIPS to require measure testing, harmonization, and clinician feedback to improve the quality of QCDR measures available for clinician reporting. CMS also finalized the proposed episode-based measures in the cost performance category to more accurately reflect the cost of care that specialists provide. Further, CMS also finalized the revised total per capita cost and the Medicare Spending per Beneficiary (MSPB) measures.

CMS did not finalize its proposal to weight the cost performance category at 20% for the 2022 MIPS payment year. Instead, CMS will continue to weigh the cost performance category at 15% in light of concerns noted regarding more detailed and actionable performance feedback. Hence, CMS will also continuing to weigh the quality performance category at 45%. However, CMS will revisit increasing the weight of the cost performance category in next year's rulemaking to ensure clinicians are prepared for the significant increase in category weight by the 2024 MIPS payment year.

Further, CMS will not finalize its proposal to set the additional performance threshold at 80 points for the 2022 MIPS payment year and instead are finalizing the additional performance threshold at 85 points for the 2022 and 2023 MIPS payment year.
