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AAHKS AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

**MEMORANDUM**

**To:** AAHKS **From:** Epstein Becker & Green, P.C.

**Date:** August 5, 2019

**Re:** Summary of the CY 2020 Physician Fee Schedule Proposed Rule

The Centers for Medicare & Medicaid Services (CMS) published the CY 2020 Proposed Payment Policies under the Medicare Physician Fee Schedule and Other Revisions to Part B on July 29, 2019. The following is a summary of CMS policy proposals. CMS is seeking feedback and comments no later than September 27, 2019.

## I. Updates to Quality Payment Program: MIPS Value Pathways - Request for Information

CMS states an intention to move toward what they say would be a more streamlined MIPS program. To advance this goal for the 2021 MIPS performance period, CMS intends to reduce reported complexities with data submission, confusion surrounding measure selection, and lower barriers to APM participation through a new framework called MIPS Value Pathways (MVPs). CMS discusses a very loose framework of what MIPS Value Pathways may be for 2021.

- The MVP framework would create sets of measure options that CMS says would be more relevant to clinician scope of practice and meaningful to patient care by connecting MIPS measures across the four performance categories specific to specialty or condition. It would also incorporate a set of administrative claims-based quality measures that focus on population health and provide data and feedback to clinicians

- The current MIPS specialty measure would serve as framework for developing these new MVPs. CMS also indicates it will enhance information provided to patients, possibly through new forms of public reporting

- MIPS-eligible clinicians would no longer choose their measures from a single inventory, but would instead fulfill measures and activities connected to a specialty or condition as a part of an MVP. This means the MIPS program would no longer require the same number of measures or activities for all clinicians

- An MVP would use a single benchmark for each measure, and all clinicians and groups in the MVP would be compared against the same standard. Scoring policies would be evaluated to ensure scoring across MVPs is equitable, so that clinicians reporting a specific MVP are not unfairly advantaged
- MVPs will focus on bundling quality measures with existing, related cost measures and improvement activities as CMS sees feasible

CMS seeks feedback on this general framework.

## II. Episode-Based Cost Performance Measures for the 2020 Performance Period

Following work of a measure development contractor, which included the input of a Technical Expert Panel and a clinical subcommittee, CMS proposes to add 10 newly developed episode-based measures to the cost performance category for the 2020 performance period. Episode-based measures compare clinicians on the basis of the cost of the care clinically related to their initial treatment of a patient and provided during the episode's timeframe.

The newly developed cost performance measures include a procedural measure: *Elective Primary Hip Arthroplasty*.

## III. Proposed Policies for CY 2021 for Office/Outpatient Evaluation and Management (E/M) Visits

In 2019, CMS emphasized that coding, payment, and documentation requirements for E/M visits are overly burdensome and no longer aligned with the current practice of medicine. To alleviate and mitigate the burden, CMS proposed to collapse 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. Specifically, in 2019, CMS finalized the following E/M changes to be effective in 2021:

- Pay a single rate for E/M office/outpatient visit levels 2 - 4 for established and new patients. The payment rate for E/M office/outpatient visit level 5 would be maintained in an effort account for the care and needs of complex patients

- Establish add on codes that describe additional resources inherent in visits for primary care and specific non–procedural specialized medical care associates with levels 2 – 4 visits

Since finalizing these policies, CMS hosted a series of listening sessions on the changes for office/outpatient E/M visit coding, documentation and payment. In response, an AMA CPT Joint Workgroup on E/M met to develop an alternative approach, similar to those CMS finalized, for E/M coding and documentation. That approach was approved by the CPT Editorial Panel in February 2019.

CMS is now proposing to modify its E/M changes by adopting the new coding, prefatory language, and interpretive guidance framework issued by the Workgroup as follows:

- Separate payment for the five levels of office/outpatient E/M visit CPT codes, as revised by the CPT Editorial Panel effective January 1, 2021 and resurveyed by the AMA 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

- Adoption of the following time rages within codes as revised by the CPT Editorial Panel:

**TABLE 26: Total Proposed Practitioner Times for Office/Outpatient E/M Visits When Time Is Used to Select Visit Level**

| Established Patient Office/Outpatient E/M Visit (Total Practitioner Time, When Time is Used to Select Code Level) | CPT code |
|---|---|
| 40–54 minutes | 99215 |
| 55-69 minutes | 99215x1 and 99XXXx1 |
| 70-84 minutes | 99215x1 and 99XXXx2 |
| 85 or more minutes | 99215x1 and 99XXXx3 or more for each additional 15 minutes |
| **New Patient Office/Outpatient E/M Visit (Total Practitioner Time, When Time is Used to Select Code Level)** | **CPT code** |
| 60-74 minutes | 99205 |
| 75-89 minutes | 99205x1 and 99XXXx1 |
| 90-104 minutes | 99205x1 and 99XXXx2 |
| 105 or more minutes | 99205x1 and 99XXXx3 or more for each additional 15 minutes |

- Choice of time or medical decision making intensity to determine the level of code (using the revised CPT interpretive guidelines for medical decision making)

- Delete the HCPCS add-on code for extended visits (GPRO1) finalized last year and instead adopt for 2021 the new CPT code 99XXX (Prolonged Office/Outpatient E/M), along with the RUC recommended values (15 minutes of physician time and a work RVU of 0.61)

- Revise the descriptor for HCPCS code GPC1X (Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to level 2 through 4 office/ outpatient evaluation and management visit, new or established)), and increase its value and allow it to be reported with all office/outpatient E/M visit levels

- Delete HCPCS code GCG0X (Visit complexity inherent to evaluation and management associated with non-procedural specialty care)

CMS seeks comment on these proposals, as well as any additional information stakeholders can provide on the appropriate valuation for these services.

## IV. Potentially Misvalued Codes

CMS has proposed the following codes as potentially misvalued for CY2020:

| CPT/HCPCS Code | Short Description |
|---|---|
| 10005 | Fine needle aspiration biopsy w/us gdn 1st lesion |
| 10021 | Fine needle aspiration biopsy w/o img gdn 1st lesion |
| 76377 | 3d render w/ intrp postprocess |
| G0166 | External counterpulse, per tx |

There is no discussion in the proposed rule of joint replacement as a potentially misvalued code, nor of the public nomination process for misvalued codes.

## V. Global Surgical Packages

In 2014, CMS proposed transforming all 10- and 90-day global surgery packages to 0-day global packages. In 2015 Congress legislatively blocked CMS from implementing this proposal and instead directed CMS to collect data on the number and level of post-operative visits to enable CMS to assess the accuracy of global surgical package valuation.

CMS collected data on pre- and post-operative services through claims and direct survey of 5,000 practitioners, stratified by specialty, geography, and practice type, with at least 311 (high volume utilizers) reporting practitioners from each specialty.

CMS is now releasing 3 reports prepared based on that data collection and is giving the public and stakeholders time to study the reports along with this rule and consider an appropriate approach to revaluing global surgical procedures.

## VI. Comment Solicitation on Opportunities for Bundled Payments under the PFS

CMS, through its Center for Medicare and Medicaid Innovation (CMMI, or the Innovation Center) interested in exploring new options for establishing PFS payment rates or adjustments for services that are furnished together. CMS seeks public comments on opportunities to expand the concept of bundling to recognize efficiencies among physicians' services paid under the PFS and better align Medicare payment policies with CMS's broader goal of achieving better care for patients, better health for communities, and lower costs through improvement in our health care system.

## VII. Aligning Patient Assessments in ASCs

CMS intends to make ASC patient evaluation standards more consistent by allowing the option for the same clinician to complete both pre- and post-procedure anesthesia evaluations. CMS proposes to revise ASC conditions of coverage regulations to allow an anesthetist (CRNA practicing within a state's scope of practice laws) *or* a physician to examine and evaluate the patient before surgery for both the anesthesia risk *and* the planned procedure risk.

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