hfma
healthcare financial management association

HFMA Physician Fee Schedule – Non-QPP Components
Executive Summary
CY 2020 Final Rule

Key Financial and Operational Impacts from the final 2020 PFS Rule:

The calendar year (CY) 2020 physician fee schedule (PFS) final rule will be published in the *Federal Register* on November 15, 2019. A detailed summary of the rule is available here. Below are key changes in the final rule.

1) **Conversion Factor**: The conversion factor (CF) for CY 2020 is $36.0896, which reflects the 0.00% update adjustment factor specified under the BBA of 2018 and a budget neutrality adjustment of 0.14% (2019 conversion factor of $36.0391*1.00*1.0014). The 2020 anesthesia conversion factor is $22.2016.

   On a specialty-specific basis, the table below shows CMS's estimates of the positive impact of the combined finalized policies.

Specialty	Allowed Charges (millions)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
clinical social worker	$787	0%	3%	0%	4%
clinical psychologist	$793	1%	2%	0%	3%
podiatry	$2,017	0%	1%	0%	2%

   The table below shows the estimated negative impact of these changes by specialty.

Specialty	Allowed Charges (millions)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Ophthalmology	$5,413	-2%	-2%	0%	-4%
diagnostic testing facility	$703	0%	-3%	0%	-3%
cardiac surgery	$281	-1%	-1%	0%	-2%
neurology	$1,512	-1%	-1%	0%	-2%
optometry	$1,335	0%	-1%	0%	-2%
vascular surgery	$1,211	0%	-2%	0%	-2%

   Exhibit I provides a complete list of impacts by specialty.

2) **Payment for Evaluation and Management (E/M) Visits:** The CY 2020 rule finalizes the following changes for E/M visits:
   a. Adopting revised code descriptors for 99202-99215 as they appear in the CPT 2021 Edition, and their associated prefatory language and instructional guidance, as well as accepting the deletion of 99201.
   b. Allowing practitioner choice of time or medical decision making (MDM) as the basis for visit level selection, (using the revised CPT interpretive guidelines for MDM). This

includes eliminating the option for visit level selection based on history and/or physical examination and eliminating the level 2 minimum documentation audit standard.

c. Deleting HCPCS code GPRO1 and adopting new CPT code 99XXX for prolonged office/outpatient E/M visits. These changes include no longer recognizing CPT codes 99358-99359 for separate payment in association with office/outpatient E/M visits.
d. Revising the descriptor for the resource cost, add-on code, HCPCS code GPC1X for use with all qualifying office visit services and deleting HCPCS code GCG0X.
e. Deleting the level 2-4 blended payment rates; restoring separate payment for each visit level of the office/outpatient E/M codes as revised for the CPT 2021 Edition; adopting the Relative Value Scale Update Committee (RUC)-recommended revaluations; and deleting the minimum level 2 visit documentation audit standard, as proposed.

3) **Physician Supervision for Physician Assistant (PA) Services:** In the rule, CMS finalizes its proposal on PA physician supervision to require the following:
    a. That a PA must furnish their professional services in accordance with state law and state scope of practice rules for PAs in the state in which the PA's professional services are furnished. Any state laws or state scope of practice rules that describe the required practice relationship between physicians and PAs, including explicit supervisory or collaborative practice requirements, describe a form of supervision for purposes of section 1861(s)(2)(K)(i) of the Act.
    b. For states with no explicit state law or scope of practice rules regarding physician supervision of PA services, physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their healthcare services. Such physician supervision is evidenced by documenting at the practice level the PA's scope of practice and the working relationships the PA has with the supervising physician/s when furnishing professional services.

4) **Review and Verification of Medical Record Documentation:** CMS finalized its proposal to establish a general principle to allow the physician, the PA, or the advanced practice registered nurse (APRN) who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students, or other members of the medical team.

    In the final rule, CMS clarifies that this policy extends to PA and nurse practitioner, clinical nurse specialist, certified nurse-midwife and certified registered nurse anesthetist students as APRN students, along with medical students, as the types of students who may document notes in a patient's medical record that may be reviewed and verified rather than re-documented by the billing professional.

5) **Care Management Services:** CMS evaluated billing patterns for a number of care management program CPT/HCPCS codes and proposed multiple changes. Below is a summary by program of the finalized changes:

a. *Transitional Care Management (TCM)*: CMS finalizes its proposal to allow concurrent billing of the care management codes currently restricted from being billed with TCM. Specifically, CMS will allow concurrent billing of TCM with the 14 codes specified in Table 20 in the final rule and CPT codes 99490 and 99491. CMS also finalizes for both TCM codes the proposed increases in work RVUs and the RUC-recommended direct practice expense inputs.

b. *Chronic Care Management Services (CCM) Non-Complex Services by Clinical Staff*: CMS finalizes its proposal to create code GCCC2 (the add-on for non-complex CCM clinical staff time) as G2058 with a work RVU of 0.54 and a maximum frequency of two times within a given service period for a given beneficiary. CMS believes this code addresses an important gap in the current code set that needs to be immediately addressed.

c. *Complex CCM Services*: After consideration of comments, CMS does not finalize its proposal to create GCCC3 and GCCC4. Instead, for 2020, CMS will continue to recognize CPT codes 99487 and 99489, but with a different care planning element for purposes of Medicare billing.

d. *Principal Care Management Services (PCM)*: CMS finalizes its proposal for two codes for PCM: G2064 (proposed GPP1) and G2064 (proposed GPP2). After consideration of comments, CMS finalizes work RVU for G2064 at 1.45 instead of the proposed RVU of 1.28. CMS finalizes its proposed work RVU of 0.61 for G2064. Table 23 in the final rule shows the required elements of CCM and Table 24 show the elements of CCM, as revised in response to comments, that will be required for PCM. CMS notes that it will add G2065 to the list of designated care management services for which it allows general supervision. CMS finalizes a requirement that ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record.

6) **Therapy KX Modifier Threshold Amounts**: For CY 2020, therapy providers are required to use the KX modifier when annual per beneficiary expenditures exceed $2,080 for physical therapy and speech language pathology services combined, and $2,080 for occupational therapy services. After the beneficiary's incurred expenditures for outpatient therapy services exceed these thresholds, claims for outpatient therapy services without the KX modifier are denied.

7) **Expanded Access to Medicare Intensive Cardiac Rehabilitation (ICR):** CMS finalized modifications to existing requirements to implement coverage changes to ICR. The changes include: (1) expanding coverage of ICR to beneficiaries with chronic heart failure with left ventricular ejection fraction of 35% or less and New York Heart Association class II to IV symptoms despite being on optimal heart failure therapy for at least 6 weeks, with an effective date of February 9, 2018, and (2) providing for modifications to covered cardiac conditions for ICR, in addition to cardiac rehabilitation, as specified through an national coverage determination.

8) **Bundled Payment for Opioid Use Disorder (OUD):** CMS finalizes its proposal that an episode of care for OUD treatment services is one week – or a contiguous 7-day period. CMS did not include a maximum number of weeks for an overall course of OUD treatment. CMS proposed, but did not finalize due to technical challenges, the ability for providers to bill for a partial OUD episode.

   As proposed, CMS finalizes two types of payment bundles: (i) A payment bundle with both a drug component and a non-drug component, and (ii) a non-drug episode of care payment bundle. For the drug component, CMS believes that no geographic adjustment factor is necessary because payments for the drug component will be set based on national rates. For the non-drug component of the bundled rates, CMS finalizes its proposal to use the Geographic Adjustment Factor for a locality adjustment.

   Payment for the drug component will be based on average sales price (ASP) when the ASP is reported. If ASP data are not available, the payment amount must be based on an alternative methodology or invoice pricing until the necessary data become available. CMS plans to use invoice prices until another approach is identified. CMS will use the TRICARE rate to set the payment for the drug component of the methadone bundle and Medicaid National Average Drug Acquisition Cost data to set the payment for the drug component of the oral buprenorphine bundle.

   CMS finalizes its proposal that beneficiaries have zero copayment. CMS indicates that, as proposed, the zero copayment will be time-limited (for example, lasting through the duration of the national opioid crisis) but that it will address its continuation in future rulemaking. CMS also notes that the Part B deductible applies to OUD treatment services, as for all Part B services.

9) **Payment for Medicare Telehealth Services:** CMS finalized its proposal to add the face-to-face portions of these three services to the list:

- HCPCS code G2086: Office-based treatment for OUD, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.

- HCPCS code G2087: Office-based treatment for OUD, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.

- HCPCS code G2088: Office-based treatment for OUD, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).

10) **Medicaid Promoting Interoperability Program Requirements for Eligible Professionals (EPs):**
    a. *2020 eQCM Reporting Requirements*: For CY 2020, CMS finalizes its proposal to continue to require that Medicaid EPs report on any six electronic clinical quality measures

relevant to the EPs' scope of practice, regardless of whether they report via attestation or electronically. EPs may select any continuous 90-day period within the CY to report on and may attest to meaningful use as early as April 1, 2020.

b. *Objective 1: Protect Patient Health Information in 2021*: CMS finalizes its proposal to allow Medicaid EPs to conduct a security risk analysis at any time during 2021, even if the EP conducts the analysis after attesting to meaningful use of Certified EHR Technology (CEHRT) to the state. A Medicaid EP who has not completed a security risk analysis for 2021 by the time they attest to meaningful use of CEHRT for 2021 will be required to attest that they will complete the required analysis by December 31, 2021.

11) *Medicare Shared Savings Program (MSSP)*: For performance year 2020, for the MSSP, CMS finalizes 23 quality measures to determine Accountable Care Organizations (ACOs) quality performance. This information is based on information submitted by the ACO through the CMS web interface, calculated from administrative claims data, and collected by the Consumer Assessment of Healthcare Provider and Systems (CAHPS) for ACOs Survey. The 23 measures are included in Exhibit II. The domain weighting is included in Exhibit III.

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Exhibit I: 2020 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$237	0%	0%	0%	0%
Anesthesiology	$2,002	0%	0%	0%	0%
Audiologist	$71	0%	1%	0%	1%
Cardiac Surgery	$281	-1%	-1%	0%	-2%
Cardiology	$6,618	0%	0%	0%	0%
Chiropractor	$756	0%	0%	-1%	-1%
Clinical Psychologist	$793	1%	2%	0%	3%
Clinical Social Worker	$787	0%	3%	0%	4%
Colon And Rectal Surgery	$163	0%	1%	0%	1%
Critical Care	$349	0%	0%	0%	0%
Dermatology	$3,550	0%	1%	-1%	0%
Diagnostic Testing Facility	$703	0%	-3%	0%	-3%
Emergency Medicine	$3,035	1%	0%	1%	1%
Endocrinology	$490	0%	0%	0%	0%
Family Practice	$6,056	0%	0%	0%	0%
Gastroenterology	$1,721	0%	0%	-1%	0%
General Practice	$410	0%	0%	0%	0%
General Surgery	$2,047	0%	0%	0%	0%
Geriatrics	$188	0%	0%	0%	0%
Hand Surgery	$226	0%	1%	0%	1%
Hematology/Oncology	$1,678	0%	0%	0%	0%
Independent Laboratory	$597	0%	1%	0%	1%
Infectious Disease	$643	0%	0%	0%	0%
Internal Medicine	$10,581	0%	0%	0%	0%
Interventional Pain Mgmt	$890	0%	1%	0%	1%
Interventional Radiology	$434	0%	-2%	0%	-1%
Multispecialty Clinic/Other Phys	$149	0%	0%	0%	0%
Nephrology	$2,176	0%	0%	0%	0%
Neurology	$1,512	-1%	-1%	0%	-2%
Neurosurgery	$807	0%	0%	-1%	0%
Nuclear Medicine	$50	0%	1%	0%	1%
Nurse Anes / Anesm Asst	$1,297	0%	0%	0%	0%
Nurse Practitioner	$4,532	0%	0%	0%	0%
Obstetrics/Gynecology	$624	0%	1%	0%	1%
Ophthalmology	$5,413	-2%	-2%	0%	-4%
Optometry	$1,335	0%	-1%	0%	-2%

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(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Oral/Maxillofacial Surgery	$72	0%	0%	-1%	-1%
Orthopedic Surgery	$3,750	0%	1%	0%	1%
Other	$35	0%	0%	0%	0%
Otolaryngology	$1,230	0%	0%	0%	0%
Pathology	$1,212	0%	0%	0%	0%
Pediatrics	$64	0%	0%	0%	0%
Physical Medicine	$1,117	0%	0%	0%	1%
Physical/Occupational Therapy	$4,273	0%	0%	0%	0%
Physician Assistant	$2,650	0%	0%	0%	0%
Plastic Surgery	$373	0%	0%	0%	0%
Podiatry	$2,017	0%	1%	0%	2%
Portable X-Ray Supplier	$96	0%	0%	0%	0%
Psychiatry	$1,134	0%	1%	0%	1%
Pulmonary Disease	$1,665	0%	0%	0%	0%
Radiation Oncology And Radiation	$1,762	0%	0%	0%	0%
Radiology	$4,995	0%	0%	0%	0%
Rheumatology	$536	0%	0%	0%	0%
Thoracic Surgery	$355	-1%	0%	0%	-1%
Urology	$1,745	0%	1%	0%	1%
Vascular Surgery	$1,211	0%	-2%	0%	-2%
TOTAL	**$93,487**	**0%**	**0%**	**0%**	**0%**

** Column F may not equal the sum of columns C, D, and E due to rounding.

Exhibit II: Measure Set for Use in Establishing the Shared Savings Program Quality Performance Standard, Starting with Performance Years during 2020

Domain	ACO Measure #	Measure Title	New Measure	Method of Data Submission	Pay for Performance Phase-In R – Reporting P – Performance PY1	PY2	PY3
AIM: Better Care for Individuals							
Patient/Caregiver Experience	ACO - 1	CAHPS: Getting Timely Care, Appointments, and Information		Survey	R	P	P
	ACO - 2	CAHPS: How Well Your Providers Communicate		Survey	R	P	P
	ACO - 3	CAHPS: Patients' Rating of Provider		Survey	R	P	P
	ACO - 4	CAHPS: Access to Specialists		Survey	R	P	P
	ACO - 5	CAHPS: Health Promotion and Education		Survey	R	P	P
	ACO - 6	CAHPS: Shared Decision Making		Survey	R	P	P
	ACO - 7	CAHPS: Health Status/Functional Status		Survey	R	R	R
	ACO - 34	CAHPS: Stewardship of Patient Resources		Survey	R	P	P
	ACO - 45	CAHPS: Courteous and Helpful Office Staff		Survey	R	R	P
	ACO - 46	CAHPS: Care Coordination		Survey	R	R	P
	ACO - 8	Risk-Standardized, All Condition Readmission		Claims	R	R	P
Domain	**ACO Measure #**	**Measure Title**	**New Measure**	**Method of Data Submission**	**Pay for Performance Phase-In R – Reporting P – Performance PY1**	**PY2**	**PY3**
Care Coordination/ Patient Safety	ACO - 38	Risk-Standardized Acute Admission Rates or Patients with Multiple Chronic Conditions		Claims	R	R	P
	ACO - 43	Ambulatory Sensitive Condition Acute Composite (AHRQ Prevention Quality Indicator (PQI) #91) (version with additional Risk Adjustment)	X	Claims	R	R	P
	ACO - 13	Falls: Screening for Future Falls		CMS Web Interface	R	P	P
AIM: Better Health for Populations							
	ACO - 14	Preventive Care and Screening: Influenza Immunization		CMS Web Interface	R	P	P
	ACO - 17	Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention		CMS Web Interface	R	P	P

Preventive Health	ACO - 18	Preventive Care and Screening: Screening for Depression and Follow-up Plan		CMS Web Interface	R	P	P
	ACO - 19	Colorectal Cancer Screening		CMS Web Interface	R	R	P
	ACO - 20	Breast Cancer Screening		CMS Web Interface	R	R	P
	ACO - 42	Statin Therapy for the Prevention and Treatment of Cardiovascular Disease		CMS Web Interface	R	R	R
Clinical Care for At Risk Population - Depression	ACO - 40	Depression Remission at Twelve Months		CMS Web Interface	R	R	R
Clinical Care for At Risk Population - Diabetes	ACO - 27	Diabetes Hemoglobin A1c (HbA1c) Poor Control (>9%))		CMS Web Interface	R	P	P
Clinical Care for At Risk Population - Hypertension	ACO - 28	Hypertension: Controlling High Blood Pressure		CMS Web Interface	R	P	P

Exhibit III: Number of Measures and Total Points for Each Domain within the Shared Savings Program Quality Performance Standard, Starting with Performance Years 2020

Table 41: Number of Measures and Total Points for Each Domain within the Shared Savings Program Quality Performance Standard, Starting with Performance Years 2020

Domain	Number of Individual Measures	Total Measures for Scoring Purposes	Total Possible Points	Domain Weight
Patient/Caregiver Experience	10	10 individual survey module measures	20	25%
Care Coordination/Patient Safety	4	4 measures	8	25%
Preventive Health	6	6 measures	12	25%
At-Risk Population	3	3 individual measures	6	25%
Total in all Domains	23	23	46	100%