Hogan Lovells

Overview of Selected Provisions of the Medicare Physician Fee Schedule Proposed Rule for Calendar Year 2020

On August 14, 2019, the Centers for Medicare and Medicaid Services (CMS) published a proposed rule addressing revisions to payment policies under the Medicare Physician Fee Schedule (PFS) and other policy revisions under Part B for calendar year (CY) 2020 ("Proposed Rule").[1] CMS will accept comments on the Proposed Rule until September 27, 2019.

CMS estimates the conversion factor for CY 2020 at $36.0896, reflecting the 0% increase specified by the Protecting Access to Medicare Act (PAMA) and the budget neutrality adjustment based on the limitation of annual adjustments specified in section 1848(c)(2)(B)(ii)(II) of the Social Security Act (SSA).[2]

The cumulative effect on total Medicare payments to physicians involved in the provision of cancer care, if all of the proposals in the Proposed Rule are finalized, would be:[3]

Specialty	Allowed Charges (Millions)	Combined Impact
Hematology/Oncology	$1,673	0%
Radiation Oncology and Radiation Therapy Centers	$1,756	0%
Radiology	$4,971	-1%

At the end of this summary, we have provided a table comparing payment rates for certain drug administration codes from the third quarter 2019 payment rate to the proposed CY 2020 payment rate. The addenda containing payment rates and other information referred to in this summary are available only on the CMS web site at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-P.html. In conjunction with the Proposed Rule release, CMS also published a fact sheet, available at: https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-2.

This Summary Addresses the Following Topics in the CY 2020 Proposed Rule:

(1) Determination of Practice Expense (PE) Relative Value Units (RVUs):
   a. Proposal to crosswalk indirect PE RVUs for two new specialties

[1] 84 Fed. Reg. 40,482. Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations (Aug. 14, 2019), *available at* https://www.govinfo.gov/content/pkg/FR-2019-08-14/pdf/2019-16041.pdf ("Proposed Rule").
[2] *Id.* at 40,882-83.
[3] *Id.* at 40,884.

b. Updates to prices for existing direct PE inputs

(2) Malpractice RVUs (MP RVUs)

(3) Geographic Practice Cost Indexes (GPCIs)

(4) Potentially Misvalued Services under the PFS

(5) Telehealth Services

(6) Physician Supervision for Physician Assistants (PAs)

(7) Review and Verification of Medical Record Documentation

(8) Care Management Services

(9) Coinsurance for Colorectal Cancer Screening Tests

(10) Valuation of Specific Codes

a. SPECT-CT procedures (Current Procedural Terminology (CPT®[4]) codes 78800, 78801, 78802, 78803, 78804, 788X0, 788X1, 788X2, and 788X3)

b. Radiation therapy codes

c. Bone biopsy trocar-needle (CPT codes 20220 and 20225)

d. Biopsy of mouth lesion (CPT code 40808)

(11) Comment Solicitation on Opportunities for Bundled Payments

(12) Payment for Evaluation and Management (E/M) Visits

(13) Medicaid Promoting Interoperability Program

(14) Medicare Shared Savings Program Updates for CY 2020

(15) Updates to the Open Payments Program

(16) Solicitation of Public Comments Regarding Notification of Infusion Therapy Options Available Prior to Furnishing Home Infusion Therapy

(17) Services Furnished by Non-Physician Practitioners: Deferring to State Scope of Practice Requirements

(18) Advisory Opinions on the Physician Self-Referral (Stark) Law

(19) Quality Payment Program (QPP)

a. The Merit-based Incentive Payment System (MIPS) Value Pathway (MVP) approach for CY 2021 and beyond

b. Proposed changes to the QPP for CY 2020

(20) Collection of Information Requirements

Details about the proposed changes are provided below.

(1) *Determination of PE RVUs*

a. Proposal to crosswalk indirect PE RVUs for two new specialties

Indirect PEs generally are developed using physician survey data to calculate the PEs incurred per hour worked. However, survey data is not available for two new specialties, Medical Toxicology and Hematopoietic Cell Transplantation and Cellular Therapy, which became Medicare recognized specialties in 2018. CMS proposes to use proxy data by

[4] CPT is a registered trademark of the American Medical Association.

crosswalking the new specialties to specialties that furnish similar services. Specifically, CMS proposes to base the indirect PE RVU for Medical Toxicology on Emergency Medicine data and for Hematopoietic Cell Transplantation and Cellular Therapy on Hematology/Oncology data.[5]

b. Updates to prices for existing direct PE inputs

CMS accepts public submission of invoices as part of its process for developing payment rates for new, revised, and potentially misvalued codes.[6] For CY 2020, CMS proposes to update the prices of 30 supply and equipment codes (listed in Table 9 of the Proposed Rule) in response to invoices received from stakeholders.[7] For most of the supply and equipment items, there was an alignment between the research carried out by the contractor StrategyGen and the submitted invoice. Consistent with the policy finalized in CY 2018 to phase in the new supply and equipment pricing over four years, one third of the difference between the CY 2019 price and the final price will be implemented for CY 2020.[8]

(2) *Malpractice RVUs*

For CY 2020, CMS is conducting the statutorily required 5-year review of the MP RVUs, which coincides with the statutorily required 3-year review of geographic practice cost indices (GPCIs). The MP premium data used to update the MP GPCIs are the same data used to determine the specialty-level risk factors that are used in the calculation of MP RVUs. Thus, in addition to performing the reviews of the MP RVUs and GPCIs this year, CMS proposes to align the update of MP premium data with the update to the MP GPCIs, meaning that CMS would review, and if necessary, update the MP RVUs at least every 3 years, similar to the review and update of the GPCIs.[9]

With regards to the methodology for the proposed revision of the resource-based MP RVUs, CMS proposes to incorporate several methodological refinements to the process in past years.[10] Specifically, CMS is proposing the following:[11]

- Downloading and using a broader set of filings from the largest market hare insurers in each state, beyond those listed as “physician” and “surgeon,” to obtain a more comprehensive data set.
- Combining minor surgery and major surgery premiums to create the surgery service risk group, yielding a more representative surgical risk factor.

[5] Proposed Rule at 40,486.
[6] *Id.* at 40,500.
[7] *Id.* at 40,501-02.
[8] *Id.* at 40,504.
[9] *Id.* at 40,505.
[10] *Id.*
[11] *Id.* at 40,506.

- Using partial and total imputation to develop a more comprehensive data set when CMS specialty names are not distinctly identified in the insurer filings, which sometimes use unique specialty names.

Table 11 of the Proposed Rule contains the CY 2020 proposed risk factors by specialty and service risk group.[12] The overall impact of these changes on total allowed charges is expected to range from -1 percent to 1 percent, depending on the specialty, with most specialties seeing no changes.[13]

(3) *GPCIs*

By statute, CMS is required to review, and if necessary adjust, the GPCIs at least every 3 years.[14] For CY 2020, CMS is conducting its statutorily required 3-year review of the GPCIs[15] and proposes updates to the GPCIs and revised geographic adjustment factors (GAFs) for each PFS locality.[16] Consistent with section 1848(e)(1)(C), CMS proposes that all GPCI adjustments in CY 2020 be half of the total adjustment that otherwise would be made—such that the total GPCI adjustments are phased in over 2 years (in CYs 2020 and 2021).[17]

Going forward, CMS also proposes to align its 3-year review and update of the MP GPCI with the update of MP premium data used to determine the MP RVUs—such start, starting with the next mandated period (in CY 2023), CMS would review and update both the GPCI and the MP RVU at the same time.[18]

(4) *Potentially Misvalued Services under the PFS*

CMS is required to periodically identify potentially misvalued codes using certain criteria and make appropriate adjustments,[19] including through public nomination of potentially misvalued codes.

As part of the CY 2020 rulemaking, CMS received three public nominations for potentially misvalued codes, and CMS nominated one additional code for review.[20] CMS also received

[12] *Id.* at 40,508-09.
[13] *Id*. at 40,884-85.
[14] *See* SSA § 1848(e)(1)(c).
[15] Proposed Rule at 40,505.
[16] *See* Proposed Rule, Addendum D to E.
[17] *See* SSA § 1848(e)(1)(C) (requiring the GPCI adjustment to be one half of the ordinary adjustment for the first year, if more than one year has elapsed since the date of the last previous GPCI adjustment). *See also* Proposed Rule at 40,510 (last proposed GPCI updates were in CYs 2017 and 2018).
[18] Proposed Rule at 40,510 (The MP RVU has historically been on a 5-year review period, because the statute only requires review every 5 years. But review of the MP RVU happened to coincide with the 3-year MP GPCI review in CY 2020. And CMS now is proposing to review both the MP RVU and MP GPCI to be on a 3-year schedule to allow them to continue to coincide in future review cycles).
[19] SSA § 1848(c)(2)(B).

a comment suggesting that the E/M code set (CPT codes 99201–99215) warrants re-evaluation because it has not been reviewed in over 12 years. CMS agrees in principle that the existing office/outpatient E/M CPT codes may not be correctly valued.[21] CMS indicates that it will continue to consider opportunities to revalue these codes, in light of their significance to payment for services billed under Medicare.[22]

(5) *Telehealth Services*

CMS did not receive any requests from the public for additions to the Medicare Telehealth list for CY 2020.[23] Nevertheless, CMS proposes to add the face-to-face portions of 3 HCPCS G-codes describing new services to the telehealth list for CY 2020. Those codes are:

- GYYY1: *Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month*.

- GYYY2: *Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month*.

- GYYY3: *Office-based treatment for opioid use disorder, 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)*.

(6) *Physician Supervision for PAs*

Under current Medicare regulations at 42 C.F.R. § 410.74(a)(2)(iv), PA services must be furnished under the general supervision of a physician. Although general supervision is the most lenient type of supervision, it requires that PA services must be furnished under a physician's overall direction and control, but the physician's presence is not required during the performance of PA services. This is a higher level of supervision than is required for nurse practitioner (NPs) and clinical nurse specialist (CNSs) under Medicare rules, which simply require collaboration with a physician. In response to a request for information (RFI) published by CMS in the CY 2018 PFS Proposed Rule, however, many commenters noted that state scope of practice requirements for PAs are changing and no longer require

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[20] Proposed Rule at 40,516.
[21] *Id.* at 40,517.
[22] *Id*. CMS did not specifically solicit comments on such a revaluation, but the agency's comments suggest that CMS is considering doing so in a future rulemaking. In the CY 2019 PFS final rule, CMS finalized changes to E/M payment and documentation requirements, while the CPT Editorial Panel concurrently convened a workgroup to refine and revalue the existing E/M office/outpatient code set.
[23] *Id.* at 40,518.

physician supervision.[24] Many of those states, commenters noted, are in line with NP and CNS requirements that give PAs a more independent scope of practice and simply require collaboration with a physician.

Based on these comments and CMS's understanding of PA scope of practice changes occurring at the state licensure level, beginning in CY 2020, CMS proposes to revise 42 C.F.R. § 410.74(a)(2) to provide that the statutory physician supervision requirement for PA services at section 1861(s)(2)(K)(i) of the SSA would be met when a PA furnishes his or her services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished, with medical direction and appropriate supervision as provided by state law in which the services are performed.[25] In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medial record of the PA's approach to working with physicians in furnishing his or her services. This proposed change would substantially align the regulation on physician supervision for PA services with CMS's current regulations on physician collaboration for NP and CNS services.

(7) *Review and Verification of Medical Record Documentation*

In an effort to reduce the paperwork burden on health care professionals, CMS proposes certain changes to how certain non-physician health care professionals can document their provision of medical services, following on similar changes to documentation requirements it made for teaching physicians last year. Specifically, CMS proposes to allow a physician, a PA, or an advanced practice registered nurse (APRN, defined to include nurse practitioners, clinical nurse specialists, and certified nurse-midwives) who furnishes and bills for 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.[26] CMS also proposes "to make conforming amendments to §§ 415.172(b) and 415.174(a)(6) to also allow physicians, residents, nurses, students, or other members of the medical team to enter information in the medical record that can then be reviewed and verified by a teaching physician without the need for re-documentation."[27]

(8) *Care Management Services*

CMS proposes to revise its billing requirements for Transitional Care Management (TCM) by allowing TCM codes to be billed concurrently with any of the codes in the table below, based on Table 17 of the Proposed Rule. CMS believes that these codes complement TCM services as opposed to duplicating them.[28]

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[24] *Id.* at 40,546.
[25] *Id.* at 40,546-47.
[26] *Id.* at 40,548.
[27] *Id.*
[28] *Id.* at 40,550.

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; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service
Home and Outpatient International Normalized Ratio (INR) Monitoring Services	93792	Patient/caregiver training for initiation of home INR monitoring
	92793	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)
End Stage Renal Disease (ESRD) Services (patients who are 20+ years)	90960	ESRD related services monthly with 4 or more face-to-face visits per month; for patients 20 years and older
	90961	ESRD related services monthly with 2-3 face-to-face visits per month; for patients 20 years and older
	90962	ESRD related services with 1 face-to-face visit per month; for patients 20 years and older
	90966	ESRD related services for home dialysis per full month; for patients 20 years and older
	90970	ESRD related services for dialysis less than a full month of service; per day; for patient 20 years and older
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

CMS is seeking comment on whether the newest CPT code in the chronic care management (CCM) services family (CPT code 99491 for CCM by a physician or other qualified health

professional, established in 2019) overlaps with TCM or should be reportable and separately payable in the same service period.[29]

CMS also makes a number of proposals or comment solicitations with respect to CCM services,[30] including:

- Proposing to adopt two new G-codes to identify additional time increments for complex CCM services:
    - HCPCS code GCCC1 *(Chronic care management services, initial 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; and comprehensive care plan established, implemented, revised, or monitored. (Chronic care management services of less than 20 minutes duration, in a calendar month, are not reported separately))*, with a proposed work RVU of 0.61.
    - HCPCS code GCCC2 *(Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). (Use GCCC2 in conjunction with GCCC1). (Do not report GCCC1, GCCC2 in the same calendar month as GCCC3, GCCC4, 99491))*, with a proposed work RVU of 0.54.
    - CMS also solicits comment on whether it should limit the number of times the add-on code (HCPCS code GCCC2) can be reported in a given service period for a given beneficiary.[31]
- Soliciting comment on the proposed substitution of two G-codes for CPT codes 99487 and 99489 respectively until such time as the CPT Editorial Panel can revise these codes:[32]
    - HCPCS code GCCC3 *(Complex chronic care management services, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient; chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented,*

[29] *Id.*
[30] *Id.*
[31] *Id.* at 40,551.
[32] *Id.* at 40,552.

revised, or monitored; moderate or high complexity medical decision making; 60 minutes of clinical staff time directed by physician or other qualified health care professional, per calendar month. (Complex chronic care management services of less than 60 minutes duration, in a calendar month, are not reported separately)), with a proposed work RVU of 1.00.

- HCPCS code GCCC4 *(each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month (List separately in addition to code for primary procedure). (Report GCCC4 in conjunction with GCCC3). (Do not report GCCC4 for care management services of less than 30 minutes additional to the first 60 minutes of complex chronic care management services during a calendar month))*, with a proposed work RVU of 0.50.

- Simplifying the list of services that would be included in the typical comprehensive care plan for CCM services.[33]

CMS also proposes to make separate payment for principal care management (PCM) services, *i.e.*, care management services for an individual with a single high-risk disease as opposed to multiple chronic diseases, via two proposed new HCPCS codes:[34]

- HCPCS code GPPP1 *(Comprehensive care management services for a single high-risk disease, e.g., Principal Care Management, at least 30 minutes of physician or other qualified health care professional time per calendar month with 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)*, with a proposed work RVU of 1.28.

- HCPCS code GPPP2 *(Comprehensive care management for a single high-risk disease services, e.g. Principal Care Management, at least 30 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month with 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 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,*

[33] *Id.* at 40,552-53.
[34] *Id.* at 40,553-55.

and/or the management of the condition is unusually complex due to comorbidities), with a proposed work RVU of 0.61.

CMS also seeks comment on whether both codes are necessary to describe PCM services, whether it should also propose a code for additional time for PCM services, whether any additional requirements are necessary for documenting PCM codes, whether any of the requirements for CCM should also apply to PCM, and whether PCM codes might be duplicative of any other services.[35] HCPCS code GPPP2 would be added "to the list of designated care management services for which we allow general supervision."[36]

Finally, CMS proposes to make some updates to Chronic Care remote physiologic monitoring (RPM) service code RVUs to reflect changes to the revised code structure approved by the CPT Editorial Panel, including creation of new code 994X0 *(Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; additional 20 minutes)*. CMS also proposes to change the supervision level for codes 99457 and 994X0 to general supervision from direct supervision.[37] CMS solicits feedback on whether it would be appropriate to permit providers to seek a general consent for certain services provided through telecommunications technology as opposed to documenting verbal consent for each individual service.[38]

(9) *Coinsurance for Colorectal Cancer Screening Tests*[39]

CMS explains that beneficiaries continue to be surprised by their copayment obligations when they receive a colorectal screening procedure and polyps are discovered and removed. Although coinsurance generally does not apply to the colorectal screening procedure, it does apply if polyps are discovered and removed because Medicare considers that to be a diagnostic procedure.

CMS does not propose to revisit its interpretation of colorectal cancer screening services or to extend the cost sharing exclusion to diagnostic procedures that were initiated as cost sharing exempt screening services. Instead, CMS invites public comment on whether it should adopt notification requirements, oral or written, that physicians or their staff would be required to provide to patients prior to a colorectal cancer screening. CMS indicates that it may consider adopting such a policy in the final rule and also invites input on what mechanism, if any, CMS should use to monitor compliance with a potential notification requirement.

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[35] *Id.* at 40,554-55.
[36] *Id.* at 40,555.
[37] *Id.* at 40,555-56.
[38] *Id.* at 40,556.
[39] *Id.* at 40,556-57.

(10) *Valuation of Specific Codes*

CMS proposes updates to RVUs, PE inputs, and other inputs for the following select codes.

a. SPECT-CT procedures (CPT codes 78800, 78801, 78802, 78803, 78804, 788X0, 788X1, 788X2, and 788X3)[40]

According to CMS, "[t]he CPT Editorial Panel revised five codes, created four new codes and deleted nine codes to better differentiate between planar radiopharmaceutical localization procedures and SPECT, SPECT-CT and multiple area or multiple day radiopharmaceutical localization/distribution procedures." CMS proposes the following work RVUs for the updated SPECT-CT CPT codes as follows:

- CMS proposes a work RVU of 0.64 for CPT code 78800 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); planar limited single area (e.g., head, neck, chest pelvis), single day of imaging*) over the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) recommended work RVU of 0.70.

- CMS proposes a work RVU of 0.73 for CPT code 78801 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); planar, 2 or more areas (e.g., abdomen and pelvis, head and chest), 1 or more days of imaging or single area imaging over 2 or more days*) over the RUC recommended work RVU of 0.79.

- CMS proposes a work RVU of 0.80 for CPT code 78802 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); planar, whole body, single day of imaging*) over the RUC recommended work RVU of 0.86.

- CMS proposes to maintain the current work RVU of 1.09 for CPT code 78803 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT), single area (e.g., head, neck, chest pelvis), single day of imaging*) over the RUC recommended work RVU of 1.20.

- CMS proposes a work RVU of 1.01 for CPT code 78804 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed);*

[40] *Id.* at 40,591-93.

planar, whole body, requiring 2 or more days of imaging) over the RUC recommended work RVU of 1.07.

- CMS proposes a work RVU of 1.49 for CPT code 788X0 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest or pelvis), single day of imaging*) over the RUC recommended work RVU of 1.60.

- CMS proposes a work RVU of 1.82 for CPT code 788X1 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day of imaging, or single area of imaging over 2 or more days*) over the RUC recommended work RVU of 1.93.

- CMS proposes a work RVU of 2.12 for CPT code 788X2 (*Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day of imaging, or single area of imaging over 2 or more days imaging*) over the RUC recommended work RVU of 2.23.

- CMS proposes a work RVU of 0.47 for CPT code 788X3 (*Radiopharmaceutical quantification measurement(s) single area*) over the RUC recommended work RVU of 0.51.

CMS is also proposing to refine "the number of minutes of clinical labor allocated to the activity 'Prepare, set-up and start IV, initial positioning and monitoring of patient' to the 2-minute standard for all of the CPT codes outline in this section, except 788X3. CMS also proposes to refine equipment time formulas, equipment times, and supply quantities for these codes.

b. *Radiation therapy codes (HCPCS Codes G6001, G6002, G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015, G6016, and G6017)*[41]

[41] *Id.* at 40,604.

The CPT codes for radiation therapy were revised for CY 2015, but CMS delayed implementation of this code set, adopting instead a number of temporary G codes. Congress then implemented a freeze in payment inputs for these codes that was extended through CY 2019. CMS is proposing to continue that practice for CY 2020.

c. Bone biopsy trocar-needle (CPT Codes 20220 and 20225)[42]

CPT code 20225 (*Biopsy of liver, needle; percutaneous*) was reviewed at the January 2019 RUC meeting after CPT code 20225 "was identified as being performed by a different specialty than the one that originally surveyed th[e] service." CPT code 20220 (*Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)*) was added to that family of codes.

CMS disagrees with the RUC-recommended work RVU of 1.93 for CPT code 20220 and proposes instead a work RVU of 1.65 "based on a crosswalk to CPT code 47000." CMS also disagrees with the RUC-recommended work RVU of 3.00 for CPT code 20225 (*Biopsy, bone, trocar, or needle; superficial (eg, ilium, sternum, spinous process, ribs)*) and proposes instead a work RVU of 2.45 based on CPT code 30906 (*Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent*). CMS also proposes to replace the bone biopsy device (SF055) supply with the bone biopsy needle (SC077) in CPT code 20225.

d. Biopsy of mouth lesion (CPT Code 40808)[43]

CPT code 40808 (*Biopsy, vestibule of mouth*) was identified for valuation review because of its high intensity of work per unit of time and Medicare utilization.

CMS disagrees with the RUC-recommended work RVU of 1.05 for CPT code 40808 and proposes instead a work RVU of 1.05 based on CPT code 11440 (*Excision, other benign lesion including margins, except skin tag (unless listed elsewhere), face, ears, eyelids, nose, lips, mucous membrane; excised diameter 0.5 cm or less*). CMS also proposes to refine the clinical labor time for the "Prepare room, equipment and supplies" (CA013) activity to 3 minutes and to refine the clinical labor time for the 'Confirm order, protocol exam' (CA014) activity to 0 minutes. Finally, CMS proposes to refine the equipment time for the electrocautery-hyfrecator (EQ110) to conform to [its] established standard for non-highly technical equipment.

(11) <u>*Comment Solicitation on Opportunities for Bundled Payments*</u>

The Proposed Rule includes a wide-ranging request for comments on how CMS can expand bundled payments to more physicians' services that are paid under the PFS. CMS notes that Medicare typically makes a separate payment for each individual service furnished to a

[42] *Id.* at 40,570-71.
[43] *Id.* at 40,577.

beneficiary, but reiterates the agency's priority of "identifying and developing appropriate payment policies that aim to achieve better care and improved health for Medicare beneficiaries." To that end, 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 our communities, and lower costs through improvement in our health care system."[44] For purposes of the request for comments, CMS defines a "bundled payment" to mean circumstances where a set of services is grouped together for purposes of rate-setting and payment, and offers the Comprehensive Primary Care Plus (CPC+) model and the Oncology Care Model as examples of bundled payment models.

(12) *Payment for E/M Visits*

In the CY 2019 PFS final rule, CMS adopted a number of changes to coding, payment and documentation of E/M codes for CY 2021.[45] Since then, the CPT Editorial Panel has adopted a number of changes to the E/M code descriptors, also effective January 1, 2021, many of which are similar to the changes that CMS finalized last year.[46] As a result, the AMA RUC "has conducted a resurvey and revaluation of the office/outpatient E/M codes, and provided [CMS] with its recommendations."[47] CMS proposes to adopt the following changes for CY 2021:

- CMS proposes to adopt the new coding, prefatory language, and interpretive guidance framework that has been issued by the AMA/CPT (*see* https://www.ama-assn.org/cpt-evaluation-andmanagement) because CMS believes it would accomplish greater burden reduction than the policies CMS finalized for CY 2021 and would be more intuitive and consistent with the current practice of medicine.[48] These changes would include that CPT codes 99358-9 no longer would be reportable in association or "conjunction" with office/outpatient E/M visits and HCPCS code GPRO1 (extended office/outpatient E/M time) no longer would be needed.[49]

- CMS also proposes to adopt the RUC-recommended work RVUs for the office/outpatient E/M codes (CPT codes 99201 through 99215) and for a new prolonged services add-on code (CPT code 99XXX).[50] These proposed updated work RVUs are as follows:

    - CPT code 99202: 0.93
    - CPT code 99203: 1.6
    - CPT code 99204: 2.6

[44] *Id.* at 40,670.
[45] *Id.* at 40,670-72.
[46] *Id.* at 40,672-73.
[47] *Id.* at 40,673.
[48] *Id.*
[49] *Id.* at 40,674-75.
[50] *Id.* at 40,675-76.

- CPT code 99205: 3.5
- CPT code 99211: 0.18
- CPT code 99212: 0.7
- CPT code 99213: 1.3
- CPT code 99214: 1.92
- CPT code 99215: 2.8
- CPT code 99XXX: 0.61

- CMS proposes to remove equipment item ED021 (*computer, desktop, with monitor*) as this item is included in overhead costs.[51]

- CMS proposes to revise the descriptor for HCPCS codes GPC1X for E/M visits to "*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 chronic condition. (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established)*.[52]

- CMS proposes to delete HCPCS code GCG0X, (*Visit complexity inherent to evaluation and management associated with non-procedural specialty care including endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, interventional pain management, cardiology, nephrology, infectious disease, psychiatry, and pulmonology (Add-on code, list separately in addition to level 2 through 4 office/outpatient evaluation and management visit, new or established*), which it added last year.[53]

CMS does not propose any updates to the global surgical packages, which currently include E/M visits. However, CMS is posting three reports prepared by RAND evaluating data collected from practices with 10 or more practitioners in certain states, which were required to report CPT code 99024 for post-operative visits furnished during a global period.[54] CMS also requests stakeholder feedback on how it might revalue global surgical procedures.[55]

Finally, CMS is considering adjusting payment for other services "for which the values are closely tied to the values of the office/outpatient E/M visit codes, such as transitional care management services (CPT codes 99495, 99496); cognitive impairment assessment and care planning (CPT code 99483); certain ESRD monthly services (CPT codes 90951 through 90961); the Initial Preventive Physical Exam (G0438) and the Annual Wellness Visit

[51] *Id.* at 40,676.
[52] *Id.* at 40,677.
[53] *Id.*
[54] *Id.* at 40,679.
[55] *Id.*

(G0439)" and is seeking comment on whether it should do so.[56] There are other codes that CMS may consider for the revaluation.[57]

(13) *Medicaid Promoting Interoperability Program*

CMS proposes minor updates to the Medicaid Promoting Interoperability Program, previously known as the Medicaid Electronic Health Record (EHR) Incentive Program.[58] The program was closed to new participants in 2016 and will end with incentive payments in 2021. As in past years, many of the proposed changes are intended to align the program with the requirements for the Promoting Interoperability component of MIPS, discussed below under the updates to the QPP.

(14) *Medicare Shared Savings Program Updates for CY 2020*

CMS proposes refinements to the quality measures reported by Accountable Care Organizations (ACOs) participating in the Medicare Shared Savings Program (MSSP). As in past years, the proposed refinements are intended to better align the MSSP with the QPP and other quality-based payment systems. The proposed changes and requests for comment include:

- A proposal to remove measure ACO-14 (Preventive Care and Screening Influenza Immunization) from the MSSP measure set and to add measure ACO-47 (Adult Immunization Status), based on equivalent changes to the MIPS quality measures;
- A proposal to make measure ACO-17 (Preventive Care and Screening; Tobacco Use Screening and Cessation Intervention) pay-for-reporting for the CY 2018 performance year; and
- A proposal to make measure ACO-43 (Ambulatory Sensitive Condition Acute Composite) pay-for-reporting for the CY 2020 and 2021 performance years.
- A request for comment on how to align the MSSP quality score with the MIPS quality performance category, including the possibility of simply replacing the MSSP quality score with the MIPS quality score, and applying the MIPS quality improvement scoring methodology to the MSSP as well, for MSSP ACOs that are not excluded from MIPS as an Advanced APM.[59]

(15) *Updates to the Open Payments Program*

CMS proposes a few minor changes to the Open Payments program, which requires manufacturers of drugs and medical devices for which payment is available under Medicare or Medicaid to report most payments and transfers of value that they make to U.S. licensed physicians and teaching hospitals. Specifically, CMS proposes:

[56] *Id.*
[57] *Id.* at 40,679-80.
[58] *Id.* at 40,702-05.
[59] *Id.* at 40,705-13.

- In accordance with changes made by the SUPPORT Act, to expand the reporting requirement to cover payments and transfers of value to certified nurse midwives, certified registered nurse anesthetists, CNSs, NPs, and PAs, effective with payments and transfers of value made by covered manufacturers in CY 2021;
- Establish new "nature of payment" categories for debt forgiveness, long-term medical supply or device loans, and acquisitions; and
- When a payment or transfer of value is associated with a covered device, drug, or biological, require manufacturers to report the Device Identifier (DI) for devices and the National Drug Code (NDC) for drugs and biologicals in both the research and non-research context.[60]

(16) *Solicitation of Public Comments Regarding Notification of Infusion Therapy Options Available Prior to Furnishing Home Infusion Therapy*

The 21st Century Cures Act created a new Medicare Part B benefit for professional services related to home infusion therapy for certain drugs and biologicals that are administered intravenously or subcutaneously through a pump that is an item of durable medical equipment (DME) in the beneficiary's home. The law requires that the physician who establishes the home infusion plan must notify the beneficiary of the options available for infusion, including the beneficiary's home, the physician's office, a hospital outpatient department, etc.

In the Proposed Rule, CMS solicits comments regarding the appropriate form, manner and frequency of the notice that physicians must provide under this statutory requirement.[61] CMS notes that there are several possible forms, manners, and frequencies that a physician might use, including a verbal discussion during the visit and annotation of the treatment decision in the medical record, or providing options to the patient in writing in the hospital discharge papers or office visit summaries, and retaining a written patient attestation that the options were provided and considered.

(17) *Services Furnished by Non-Physician Practitioners: Deferring to State Scope of Practice Requirements*

CMS proposes updates to Medicare policies regarding services furnished by NPs, PAs, and other non-physician practitioners in the Ambulatory Surgical Center (ASC) and hospice settings. The proposed changes generally are intended to reduce regulatory burden by giving providers the option to have non-physician practitioners perform certain services where doing so would be consistent with that practitioner's scope of practice under state law.[62]

[60] *Id.* at 40,713-16.
[61] *Id.* at 40,716.
[62] *Id.* at 40,724-26.

(18) *Advisory Opinions on the Physician Self-Referral (Stark) Law*

In June 2018, CMS issued a RFI on how to address undue impact and burden resulting from the physician self-referral law, commonly known as the Stark Law, and its implementing regulations. CMS is deferring discussion of most of the issues raised by responses to the RFI to a separate rulemaking. But the Proposed Rule does include several proposals and requests for comment related to the process for advisory opinions issued by CMS on matters related to the Stark Law, including the following:

- Solicitation of comment on whether CMS should expand the scope of matters that may be the subject of an advisory opinion request to include requests that involve hypothetical fact patterns and general questions of interpretation, not just arrangements that the requester actually intends to enter into;
- Proposed additional reasons why CMS will reject an advisory opinion (e.g., insufficient information, or the same course of action is under investigation by a government entity);
- Proposed 60-day timeline for issuing advisory opinions;
- Proposed clarifications to the requirement to certify requests;
- Proposed updates to the fees for processing a request;
- Proposed clarifications to the ability of parties to rely on an advisory opinion; and
- Solicitation of comment on CMS's ability to rescind advisory opinions.

(19) *QPP: Proposed Updates for CY 2020 and Beyond*

CMS proposes to continue its gradual implementation of the QPP for CY 2020, while setting the groundwork for more significant changes to streamline the QPP beginning in CY 2021.

a. The MVP approach for CY 2021 and beyond

Beginning in the CY 2021 performance year, CMS proposes a transformation in the conceptual framework for MIPS, which would be called the MVP approach. Under the MVP approach, CMS would:

- Make a greater effort to connect measures and activities across the four MIPS performance categories (quality, cost, improvement activities, and promoting interoperability);
- Incorporate a new set of claims-based quality measures that focus on population health; and
- Provide greater data and feedback to clinicians and enhance the information provided to patients.

CMS would accomplish these goals through establishment of different "MIPS Value Pathways," which would be sets of measures across all four performance categories that are oriented to a specific clinical area (e.g., diabetes prevention or major

surgery) and that are standardized for all eligible clinicians who choose that MVP (i.e., all clinicians report the same measures). CMS gives several examples of possible MVPs in Table 34 of the Proposed Rule.

The Proposed Rule includes a RFI related to the proposed transition to the MVP approach, including detailed questions about the following areas:

- Process for developing different MVPs, including how to gather feedback from stakeholders, how measures and activities should be selected;
- How MVPs should be organized, e.g., around specialties and areas of practice or around public health priorities;
- How CMS should determine which MVP(s) are most appropriate for a given clinician;
- Adjustment of MVPs for small and rural practices and multi-specialty practices;
- Incorporation of Qualified Clinical Data Registries (QCDRs) into the MVP approach;
- How MVP performance should be scored;
- Development of MVP population health measures; and
- Clinician data feedback and enhanced information for patients.

b. Proposed changes to the QPP for CY 2020

In the meantime, for CY 2020, CMS proposes to retain the essential structure of the QPP that CMS used for CYs 2017 and 2018: clinicians must choose between two tracks – pay for performance MIPS (resulting in a Part B payment bonus or penalty of up to nine percent) or successful participation in an Advanced APM (resulting in exemption from MIPS and a Part B payment bonus of five percent). CMS makes the following proposals to refine the program for CY 2020:

- CMS proposes to increase the weight of the MIPS cost component from 15 percent of the overall score to 20 percent. The weight of the quality score would decrease from 45 percent to 40 percent. In CY 2021, the weights would be 25 percent cost and 35 percent quality, and in CY 2022, CMS would finally reach the statutory mandate of 30 percent weight for both quality and cost. With respect to the cost measures, CMS proposes to modify the two overall spending measures that it finalized in CY 2018, retain eight existing episode-based cost measures, and add ten new ones.

- CMS proposes to increase the data completeness threshold for quality measures from 60% to 70% in CY 2020.

- CMS proposes to impose new and more stringent requirements on QCDRs that are responsible for reporting certain quality measure data for MIPS

eligible clinicians, including new requirements for measure testing, harmonization, and clinician feedback.

- CMS proposes to continue refining the quality measures available for reporting under MIPS, including by eliminating existing measures that do not meet case minimum and reporting volumes required for benchmarking for 2 consecutive years, and revising the way quality measures are scored by introducing a "flat benchmark" for certain measures that are close to topped out.

- CMS proposes to add just 4 new quality measures for CY 2020, including measures for:

    - A prostate symptom score after diagnosis of benign prostatic hyperplasia (BPH)
    - Multimodal pain management
    - Adult immunization status
    - Functional status change for patients with neck impairments

- CMS also proposes to add 1 quality measure for CY 2021: All-cause unplanned admission for patients with multiple chronic conditions.[63]

- CMS proposes to remove 55 existing quality measures for CY 2020.[64]

- CMS also proposes new specialty measure sets and modifications to the measures included in existing specialty measure sets,[65] including changes to the specialty measure sets for:

    - Oncology/Hematology, including new measures for myelodysplastic syndrome and acute leukemia testing performed on bone marrow; multiple myeloma treatment with biophosphonates; chronic lymphocytic leukemia baseline flow cytometry; and adult immunization status; and removal of 7 existing measures
    - Diagnostic Radiology

- CMS proposes to introduce 10 new episode-based cost measures across a wide range of clinical areas, including measures for:

    - Lumpectomy, partial mastectomy, simple mastectomy.

[63] The proposed new measures are listed in the Proposed Rule at Appendix 1, Table A.
[64] The proposed measures to be removed are listed in the Proposed Rule at Appendix 1, Table C.
[65] The full list of proposed changes to the specialty measure sets and the proposed new specialty measure sets are listed in the Proposed Rule at Appendix 1, Table B.

- CMS also proposes to make changes to the existing overall cost measures (total per capita cost and Medicare spending per beneficiary), including changes to how costs are attributed to eligible clinicians for both measures.

- CMS proposes to require 50% of a group to participate in an improvement activity for the group to get credit for that activity (currently only requires a single member of the group to participate).

- In terms of the impact of an eligible clinician's score on Medicare Part B reimbursement, CMS proposes to increase the performance threshold (number of points needed to be eligible for a bonus) to 45 points, with an additional performance threshold (number of points needed for maximum bonus) to 80 points. For CY 2021, these thresholds would increase to 60 points and 85 points.

- The maximum penalty for CY 2020 performance is -9%, and the maximum bonus for CY 2020 performance is +9%, though this is adjusted by a scaling factor for budget neutrality that could push the actual bonus above or below +9%.

- CMS does not propose any major changes to calculating of the composite score; eligible clinician eligibility and exemptions; special scoring rules; or virtual groups for CY 2020.

With respect to the Advanced Alternative Payment Model (Advanced APM) track within the QPP, CMS proposes certain refinements to the existing rules for CY 2020, including the following:

- CMS proposes that eligible clinicians who earn partial qualifying participant (QP) status and exclusion from MIPS would earn that status only with respect to the TIN/NPI combination(s) through with the eligible clinician earned QP status, and not any other TIN/NPI combination(s) under which the eligible clinician bills.

- CMS proposes to average the marginal risk rate that eligible clinicians take on through "Other Payer Advanced APMs", rather than taking only the lowest rate, for purposes of determining whether the APM meets the 30% marginal risk rate.

- CMS proposes that, where an eligible clinician is unable to receive a quality score through a MIPS APM, eligible clinicians would receive a MIPS quality score but would receive a 50% credit toward that score.

(20) *Collection of Information Requirements*

Consistent with the requirements of the Paperwork Reduction Act of 1995 (PRA), CMS requests public comments regarding the following issues for certain proposed information collection requests (ICRs): (1) the need for information collection and its usefulness in carrying out CMS's proper functions; (2) the accuracy of CMS's published burden estimates; (3) the quality, utility, and clarity of the information to be collected; and (4) CMS's effort to minimize the information collection burden on the affected public, including the use of automated collection techniques.

CMS seeks comment on these issues in connection with the following ICRs of potential interest:

- Open Payments Program. CMS proposes to (1) expand the definition of "covered recipient" in accordance with the SUPPORT Act to include PAs, NPs, CNSs, nurse anesthetists, and certified nurse midwives; (2) modify "nature of payment" categories; and (3) standardize data on reported covered drugs, devices, biologicals, or medical supplies. With respect to the expanded definition of "covered recipient", the agency notes that Section 6111(c) of the SUPPORT Act provides that the PRA does not apply to the definition of a covered recipient included in the SUPPORT Act.

  With regard to the modification of the "nature of payment" categories to provide more options for applicable manufacturers and group purchasing organizations (GPOs) to capture the nature of the payment made to the covered recipient, CMS projects that reporting entities would need to update their system to incorporate the proposed categories. CMS estimates that there are 1,600 reporting entities and that about 25 percent of the reporting entities (400) would need to make minor, one-time updates to their data collection processes. For those 400 entities, CMS estimates a one-time burden of 13,662 hours at a cost of $675,745 across all entities to make the adjustments.[66]

  Finally, with regard to standardized data reporting for covered drugs, devices, biologicals, or medical supplies CMS notes that applicable manufacturers and GPOs will need to accommodate the reporting of device identifiers. CMS estimates that approximately 850 entities would need to report at least one record with a device identifier and that 450 of those entities do not already collect the device identifier.[67] The burden for all 850 entities expected to need to report is 51,577 hours at a cost of $2,440,937.[68]

[66] Proposed Rule at 40,840.
[67] *Id.* at 40,840-41.
[68] *Id.* at 40,842.

- QPP. The QPP is comprised of a series of ICRs associated with MIPS and Advanced APMs.

    - The MIPS ICRs consist of: registration for virtual groups; qualified registry self-nomination applications; and QCDR self-nomination applications; CAHPS survey vendor applications; Quality Payment Program Identity Management Application Process; quality performance category data submission by Medicare Part B claims collection type, QCDR and MIPS CQM collection type, eCQM collection type, and CMS web interface submission type; CAHPS for MIPS survey beneficiary participation; group registration for CMS web interface; group registration for CAHPS for MIPS survey; call for quality measures; reweighting applications for Promoting Interoperability and other performance categories; Promoting Interoperability performance category data submission; call for Promoting Interoperability measures; improvement activities performance category data submission; nomination of improvement activities; and opt-out of Physician Compare for voluntary participants.[69]

    - ICRs for Advanced APMs consist of: Partial Qualifying APM participant (QP) election; Other Payer Advanced APM identification: Payer Initiated and Eligible Clinician Initiated Processes; and submission of data for All-Payer QP determinations under the All-Payer Combination Option.[70]

    - The agency provides information relating to its burden estimates and related assumptions for MIPS and Advanced APMs.[71]

[69] *Id.* at 40,842-43.
[70] *Id.* at 40,843.
[71] *Id.* at 40,843-80.

Comparison of 2020 Proposed Rule and Q3 2019 Physician Fee Schedule Payment Rates for Drug Administration Services

CPT Code	Description	CY 2020 Proposed Payment		Q3 CY 2019 Payment		% Change	
		Non Facility	Facility	Non Facility	Facility	Non Facility	Facility
96360	Hydration iv infusion init	$34.65	N/A	$38.56	N/A	-10.15%	N/A
96361	Hydrate iv infusion add-on	$13.71	N/A	$13.69	N/A	0.14%	N/A
96365	Ther/proph/diag iv inf init	$71.46	N/A	$72.80	N/A	-1.84%	N/A
96366	Ther/proph/diag iv inf addon	$22.01	N/A	$21.98	N/A	0.14%	N/A
96367	Tx/proph/dg addl seq iv inf	$31.40	N/A	$31.71	N/A	-1.00%	N/A
96368	Ther/diag concurrent inf	$21.29	N/A	$21.26	N/A	0.14%	N/A
96369	Sc ther infusion up to 1 hr	$161.32	N/A	$169.02	N/A	-4.56%	N/A
96370	Sc ther infusion addl hr	$15.52	N/A	$15.86	N/A	-2.14%	N/A
96371	Sc ther infusion reset pump	$64.60	N/A	$66.31	N/A	-2.58%	N/A
96372	Ther/proph/diag inj sc/im	$14.44	N/A	$16.94	N/A	-14.77%	N/A
96373	Ther/proph/diag inj ia	$18.77	N/A	$19.10	N/A	-1.75%	N/A
96374	Ther/proph/diag inj iv push	$40.06	N/A	$39.64	N/A	1.05%	N/A
96375	Tx/pro/dx inj new drug addon	$16.60	N/A	$16.94	N/A	-1.99%	N/A
96376	Tx/pro/dx inj same drug adon	$0.00	$0.00	$0.00	$0.00	N/A	N/A
96379	Ther/prop/diag inj/inf proc	$0.00	$0.00	$0.00	$0.00	N/A	N/A
96401	Chemo anti-neopl sq/im	$79.76	N/A	$80.73	N/A	-1.20%	N/A
96402	Chemo hormon antineopl sq/im	$31.76	N/A	$31.35	N/A	1.29%	N/A
96405	Chemo intralesional up to 7	$84.81	$30.68	$83.25	$30.27	1.87%	1.33%
96406	Chemo intralesional over 7	$129.56	$47.28	$124.70	$47.21	3.90%	0.14%
96409	Chemo iv push sngl drug	$109.35	N/A	$109.92	N/A	-0.52%	N/A
96411	Chemo iv push addl drug	$59.19	N/A	$59.46	N/A	-0.47%	N/A
96413	Chemo iv infusion 1 hr	$141.47	N/A	$143.08	N/A	-1.12%	N/A
96415	Chemo iv infusion addl hr	$30.68	N/A	$30.99	N/A	-1.02%	N/A
96416	Chemo prolong infuse w/pump	$141.47	N/A	$143.44	N/A	-1.37%	N/A
96417	Chemo iv infus each addl seq	$68.57	N/A	$69.20	N/A	-0.90%	N/A
96420	Chemo ia push tecnique	$104.66	N/A	$106.32	N/A	-1.56%	N/A
96422	Chemo ia infusion up to 1 hr	$172.87	N/A	$174.79	N/A	-1.10%	N/A
96423	Chemo ia infuse each addl hr	$80.12	N/A	$80.73	N/A	-0.75%	N/A
96425	Chemotherapy infusion method	$184.42	N/A	$185.24	N/A	-0.44%	N/A
96440	Chemotherapy intracavitary	$908.74	$129.92	$854.13	$129.02	6.39%	0.70%
96446	Chemotx admn prtl cavity	$204.63	$26.71	$208.31	$28.47	-1.77%	-6.20%
96450	Chemotherapy into cns	$183.34	$81.92	$184.88	$81.81	-0.84%	0.14%
96521	Refill/maint portable pump	$147.97	N/A	$148.84	N/A	-0.59%	N/A

CPT Code	Description	CY 2020 Proposed Payment		Q3 CY 2019 Payment		% Change	
96522	Refill/maint pump/resvr syst	$123.07	N/A	$122.17	N/A	0.73%	N/A
96523	Irrig drug delivery device	$27.79	N/A	$27.75	N/A	0.14%	N/A
96542	Chemotherapy injection	$132.45	$42.95	$135.87	$42.89	-2.52%	0.14%