2020 Physician and Freestanding Facility Regulatory Update

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The Medicare Physician Fee Schedule (MPFS) is one of the Medicare payment systems that applies to physicians (even those employed by hospitals) and non-facility-based settings, which include offices, freestanding facilities, and nonexcepted off-campus provider-based departments. Reimbursement under MPFS is based on relative value units (RVUs) that represent the work, practice expense (direct and indirect), and malpractice values assigned to each code. RVUs are then factored with the geographic practice cost indices (GPCI)—the geographic locale as identified by Medicare—to determine exact payments based on location.

CY 2020 begins the MPFS payment system's transition away from the traditional, historical, fee-for-service model that is impacted by the changing conversion factor (CF) to a payment system that is set, with the only potential changes related to budget neutrality. This transition was mandated as part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). Under MACRA, beginning in CY 2020 the CF is frozen at the CY 2019 value with no increases for the next five years. The CY 2019 CF is $36.0391. Therefore, this value is still used for CY 2020 with direct adjustment.

The CMS budget must be maintained within $20 million each year. When projections anticipate that the impact from any RVU changes will be outside the expected budget, a budget neutrality factor is applied to the CF to bring it back into range and maintain budget neutrality. For CY 2020, CMS is applying a positive 0.14 percent budget neutral adjustment to the CF, which will result in an overall increase in payments, with a CF value of $36.0896. Even with the slight increase overall by CMS, the impact on both hematology/oncology and radiation oncology reflects no percentage adjustment for CY 2020.

Relative Value Units (RVUs) Updates

Malpractice RVUs attempt to quantify the risk associated by a given specialty in alignment with the malpractice premiums paid by that specialty in relation to the services performed and reported through claims data. For CY 2019, CMS requested feedback regarding the next update of malpractice RVUs as required by CY 2020, specifically how improvements in the way specialties in the state-level raw rate-filings data are cross-walked to the CMS specialty codes, which are used to develop the specialty-level risk factors and the malpractice RVUs.

For CY 2020 CMS proposed that the values of the malpractice RVUs and the malpractice GPCI be coordinated because updates to both are based on the same malpractice premium data. Thus, CMS believes any changes to the malpractice RVUs would be aligned and relative to the changes in the malpractice GPCI. No comments to this proposal were received; CMS finalized the proposed changes without revision. This change puts the next mandated review for implementation in CY 2023.

Practice expense (PE) accounts for the resources provided by the physician and practitioner such as, office rent and personnel wages, but excludes expenses for malpractice. Practice expenses are further classified as direct and indirect. Direct PE categories include clinical labor, medical supplies, and medical equipment; indirect expenses include administrative labor, office expenses, and all other expenses.

Beginning in CY 2020, CMS will recognize two new specialties for which it will be calculating specific values related to practice expense (PE) RVUs— Medical Toxicology and Hematopoietic Cell Transplantation and Cellular Therapy. Both specialties were recognized by CMS during 2018. Each will have values related to the direct practice expense category (clinical labor, medical supplies, and medical equipment), as well as indirect expense category (administrative labor, office expense, and all other expenses) valued into their procedure codes.

Comments were received related to several specific radiation oncology items. Commenters stated that the non-facility PE RVUs for **CPT 55874**, (transperineal placement of biodegradable material, periprostatic, single or multiple injections, including image guidance, when performed), are projected to decrease by 13 percent for CY 2020 when compared to CY 2019. Commenters believed this was attributable to the mix of specialties utilizing and billing for the service. The value of the code was based on claims data from the first year in which the mix was urology and radiation oncology specialties reporting the code and this differs from the current reporting mix which can change the value of the code.

CMS agreed with commenters that the proposed decreases in the PE RVUs for **CPT**

Table 4. Revaluation of HCPCS Add-on G code Finalized for CY 2021

HCPCS CODE	PROPOSED CODE DESCRIPTOR REVISIONS	FR 2019 TOTAL TIME (MINS)	FR 2019 WORK RVU	TOTAL TIME (MINS)	WORK RVU
GPC1X	*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)*	8.25	0.25	**11**	**0.33**

55874 were due to changes in the specialty mix shifting from the projected utilization to reported claims data. However, CMS did not agree that the specialty mix needed to be corrected and that it is important to use actual claims data. The final PE RVUs reflect a decrease from 2019 (95.24) to 2020 (83.79) for a total change of 11.45.

Comments were also received requesting that CMS update the pricing used for the Biodegradable Material Kit – PeriProstatic, i.e., the gel used with placement code **55874**. The commenter provided invoices to support the requested updated value for the supply. CMS agreed the values of the periprostatic kit did increase in value from $2,850 to $2,965 based on submission of eight invoices and finalized a price increase. This will have an impact on the non-facility value of code **55874** that includes the supply, Biodegradable Material Kit – PeriProstatic, but not enough to off-set the previously described reduction in PE RVUs to code **55874**. So there will be no positive increase for code **55874** in CY 2020.

Comments were also received about the pricing of the "HDR Afterload System, Nucletron – Oldelft" equipment, the "treatment planning system, IMRT (Corvus w-Peregrine 3D Monte Carlo)" equipment, and the "SRS system, SBRT, six systems, average" equipment. Commenters indicated that all the equipment items had values of prices well below industry standards. Undervalue of the equipment used for treatment planning results in lower valued codes related to the services that use them. CMS was urged to conduct additional research into the equipment pricing to ensure fair market values. One commenter believed that the value reflected for the HDR afterload system may have inadvertently used electronic brachytherapy system pricing, which is considerably lower.

In its response, CMS agreed with the importance of fair market values for the equipment; however, the agency noted that commenters did not provide invoices to support their statements. Without anything to back up the comments, CMS believes the values it has reflected are appropriate and accurate. Stakeholders are welcome to submit invoices over the ongoing four-year transition period for equipment pricing.

The only codes specific to radiation oncology, which CMS addressed regarding proper valuation, are the G-codes **G6001** to **G6017** for treatment delivery and IGRT. In place since Jan. 1, 2015, these codes were set to expire on Dec. 31, 2019, when replaced with an alternative payment model under MPFS. In early July 2019 CMS released a Radiation Oncology (RO) Payment Model proposed rule. At publication of the CY 2020 MPFS final rule, the RO Model was still proposed. In the final CY 2020 MPFS rule, CMS states it will continue the valuation of the G-codes with the current work RVUs and direct PE inputs. Further, for 2020 CMS will continue to include the utilization rate assumption of 60 percent in the values for the IMRT accelerator.

CMS also received comments regarding code **G6107**, Intrafraction localization and tracking of target or patient motion during delivery of radiation therapy (e.g., 3D positional tracking, gating, 3D surface tracking), and the request to assign RVUs to the contractor priced code as well as **CPT 77387.** Guidance for localization of target volume for delivery of radiation treatment, includes intrafraction tracking, when performed, which is not recognized under MPFS, but is recognized under OPPS. Commenters stated that if CMS would assign a value to **77387** under MPFS this would assist providers as they work to negotiate values with commercial payers and clear the confusion created by the use of the G-codes in place of the CPT codes.

CMS stated that introduction of the RO Payment Model necessitates maintaining the current values and recognition of the codes as they exist now. To add values to codes that did not previously exist would create issues and disruption to the proposed RO Payment Model and ongoing reimbursement policies. Table 4, above, lists the finalized RVUs of the G-codes for 2020.

Evaluation and Management (E/M) Guidelines

After publication of the CY 2019 MPFS final rules, it was clear that CMS was aiming to make sweeping changes to E/M guidelines. Most of the changes outlined in the 2019 MPFS final rule were slated for CY 2021 so that stakeholders would have time to prepare and the AMA would have time to jump on board and align its guidelines with CMS.

However, in the CY 2020 MPFS proposed ruling, CMS outlined the cancelation of most, if not all, of the proposed changes and adjustments to the initial updates for E/M guidelines that were intended for release by the AMA for CY 2021. CMS indicated that the agency had received thousands of comments to the CY 2020 proposed rule specific to E/M changes.

Some of the changes finalized by CMS were established by the AMA and approved by CMS for their beneficiaries, including the following:

- Only the option of using either time or medical decision-making (MDM) to select the code level
- Elimination of the ability to use the history and exam, or time in combination with the MDM to select the final code level
- Deletion of code **99201**; effective Jan. 1, 2021
- Time values assigned to code levels
- Inclusion of all time spent on the date of the visit.

After several CMS stakeholder meetings, much of the feedback the agency received related to the single payment rate for E/M levels 2 through 4 of outpatient office visits. Many stakeholders voiced concerns that paying the same amount regardless of level would incentivize providers to spend as little time as necessary or just the minimum to qualify for payment, rather than spend more time as beneficial for patients. Other feedback included requests that time be the only tool for determining the level of visit as it is easy to audit, document, consistently interpret, and better accounts for complexity levels. To assist in understanding what these changes may mean, the AMA published an estimate of anticipated burden reduction relative to its policies that CMS has also accepted for use and provided within the final rule. The estimate can be found on the AMA website, ama-assn.org/cpt-evaluation-and-management.

Given the information and feedback the AMA received when conducting its own surveys, CMS proposed and finalized the following for CY 2021:

- Assign separate reimbursement amounts to each visit code level instead of one rate for levels 2 through 4, except code **99201**, which will be deleted in CY 2021
- Recognition and reimbursement for the new prolonged visit add-on code (**CPT code 99XXX,** still to be revealed by AMA) and allow for its use with levels 2 through 4 and level 5
- CMS to no longer recognize prolong services codes **99358** and **99359** for separate reimbursement when associated with outpatient E/M visits
- Deletion of HCPCS add-on code **GPRO1** for extended visits
- Elimination of history and/or physical exam in determining billable code level
- Choice of either time or MDM to decide level of outpatient, new or established patient visit, using the AMA CPT guidelines for MDM
- Consolidate and revalue primary care and non-procedural medical care codes (**GPC1X** and **GCG0X**) into one HCPCS code: **GPC1X,** which will have an increased value and be reportable with all of the outpatient E/M visit codes.

With CMS adoption of these new guidelines for CY 2021, history and exam will no longer affect code level. The visit will only include history and exam if they are pertinent to the visit and when performed. The number of body systems reviewed will no longer be documented and, again, will only be included as pertinent to the visit itself. Level 1 visits (**99211**) will describe or include those visits performed by clinical staff for established patients and will not include medical decision-making.

The individual levels of codes 2 through 5 would be based on MDM, as defined in the updated AMA guidelines, or based on time personally spent by the billing provider. Time will account for both face-to-face and non-face-to-face time. Time ranges for each code will match those revised by the AMA. There will also be an add-on for prolonged time that will be available when the time used for the code level and the base level 5 time were exceed by 15 minutes or more on the date of service of the visit. The long description for the new add-on code to be used is "prolonged office or other outpatient evaluation and management service(s) (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 minutes (List separately in addition to codes **99205**, **99215** for office or other outpatient Evaluation and Management services)."

CMS finalized that the prolonged service code will account for all time spent within the 24-hour period for the date of service of the primary E/M service code. Additionally, CMS finalized that any work performed on dates of service prior to or post the E/M visit to review medical records or tests cannot count toward the time value for the E/M outpatient visit or use of the prolonged services code, **99XXX** or **99358** or **99359**. This follows the valuation of the E/M codes to account for all-time 3 days prior to or 7 days post the actual E/M visit.

CMS published a table of the estimated financial impact of the E/M changes in CY 2021 by specialty (see Table 5, page 22).

Lifting Restrictions Related to E/M Documentation

CMS finalized several changes for CY 2020 regarding the amount of documentation necessary in the medical record related to teaching situations with residents and medical students. After considerable feedback, CMS is also extending lifting of the restrictions as they relate to teaching situations to also include PAs and APRNs paid under MPFS.

Based on stakeholder feedback, CMS finalized the following proposals with some modification:

- PA and NP, CNS, CNM and CRNA students, and 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
- To include CRNAs as a category of APRNs for purposes of this policy, and to include CRNA students under the reference to APRN students
- There is no requirement by CMS that the billing physician is the only person who can review and verify documentation in the medical record when added by

Table 5. Estimated Specialty Level Impacts of Finalized E/M Payment and Coding Policies

(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*
Hematology/Oncology	$1,673	8%	4%	1%	12%
Radiation Oncology and Radiation Therapy Centers	$1,756	-2%	-2%	0%	-4%

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

physicians, residents, nurses or students, or other members of the medical team
- This policy is not limited to E/M, but includes all types of service (E/M, procedure, diagnostic test) or setting in which the service is furnished
- The reviewer of the medical documentation does not have to be of the specialty of the student or medical team that provided the notation in the medical record.

Utilization of State Scope-of-Practice Requirements Non-Physician Practitioners

CMS recognizes that the scope-of-work provided by non-physician practitioners (NPPs) has greatly changed since 1965 when the Medicare program was signed into law. At that time, it was predominantly nurses who aided physicians. Now, non-physician practitioners include NPs and PAs. Due to these changes, CMS proposed to adjust language to include how these NPPs provide assistance.

The CY 2020 MPFS finalizes changes specific to CRNAs in the ambulatory surgical center setting and PAs in hospice. For beneficiaries in hospice care, the finalized changes mean patients can select their PA as their attending physician. Historically, PAs could not write scripts for medications or orders for care to the hospice and have them accepted without intervention by a physician. CMS is amending this language to allow for hospice to accept drug orders from a physician, NP, or PA as designated by the patient. The PA must have within their state scope-of-practice the ability to provide these services, and they must be designated as the patient's attending physician and not contracted with the hospice itself.

CMS believes this will allow for continuity of care to patients as they approach the end of life. In the event the patient's attending physician or NPP does not agree to provide this care, they do not feel comfortable with the request, the hospice is equipped to provide a hospice employed physician or NPP who will practice as the attending for the patient.

Physician Supervision of Physician Assistant (PA) Services

CMS indicated that it received ongoing requests to allow PAs to practice medicine without the requirement for supervision by a physician, to align their roles and the regulations with those for NPs and CNSs. As mentioned previously, the scope-of-work provided by PAs has changed over the years and many provide and deliver healthcare more broadly than ever before. Many of these changes have resulted in changes to the scope of work and laws in different states. Some states have relaxed their requirements related to the necessary supervision, while others have yet to make any changes.

Currently CMS requires general supervision of the PA by the physician. CMS sought comments to fully understand the roles of PAs and how the current supervision requirements impede or burden their ability to provide services to beneficiaries. Either the state scope-of-practice will define the supervision levels of services provided by the PA or if there is nothing defined by the state, the practice must define the relationship and have this in writing available in the practice. Provided below is verbiage provided by CMS regarding physician supervision for PAs:

- PAs 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.
- 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 health care 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 physicians when furnishing professional services. OI

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