

Medicare Physician Fee Schedule Final Rule for Calendar Year 2020 Detailed Summary of the Payment and Quality Payment Program Provisions

The American College of Radiology (ACR) has prepared this detailed analysis of final changes to the payment provisions of the Medicare Physician Fee Schedule (MPFS) in calendar year (CY) 2020. This summary also includes policies for implementation of the fourth year for the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Models (APMs). Changes will be effective Jan. 1, 2020.

Conversion Factor

The Centers for Medicare and Medicaid Services (CMS) finalized a CY 2020 conversion factor of \$36.0896, which is a slight increase from the current conversion factor of \$36.0391.

CMS estimates an overall impact of the final MPFS changes to radiology, radiation oncology and radiation therapy centers a neutral 0 percent, an overall 1 percent decrease for interventional radiology and a 1 percent increase for nuclear medicine.

Appropriate Use Criteria (AUC)/Clinical Decision Support (CDS)

There is no discussion on AUC/CDS pertaining to advanced diagnostic imaging services in the final rule. However, on July 26, CMS did release separate AUC [claims processing guidance](#) with additional information on the applicable HCPCS modifiers and G codes. Last year, CMS reaffirmed that the ordering providers must consult AUC when ordering advanced diagnostic imaging services to include CT, MR, PET scans, and nuclear medicine exams for Medicare patients starting January 1, 2020. Year 2020 is considered to be “Educational and Operations” testing period with no penalties.

Evaluation and Management (E/M) Services (Page 857)

For CY 2021, CMS finalized the proposal to adopt the new coding structure for the office/outpatient evaluation and management (E/M) codes as recommended by the AMA, as well as the RUC-recommended times and values. There will be separate payments for each of the five levels of office/outpatient E/M (instead of the blended payments for levels 2-4), along with a new add-on code for prolonged visits. January 1, 2021 implementation will allow additional time for feedback, provider education, and changes to workflow, updates to electronic health records (EHRs) and systems.

Office/Outpatient E/M Visit Coding and Documentation

For codes 99201-99215, CMS finalized its proposal to adopt the new coding, prefatory language, and interpretive guidance framework issued by AMA/CPT to further reduce burden of documentation. In this framework, history and exam would no longer select the level of code selection for office/outpatient E/M visits. Instead, an office/outpatient E/M visit would include a medically appropriate history and exam, when performed. Therefore, CMS proposes to eliminate the use of history and/or physical exam to select among code levels.

CMS also finalized its proposal to adopt choice of time or medical decision-making (MDM) to determine the level of office/outpatient E/M visit (using the revised CPT interpretive guidelines for medical decision-making). The Agency notes that some commenters expressed concern about potential resulting shifts in visit levels billed and among specialties as a result of these changes. CMS intends to monitor the claims data to assess any resulting changes and will continue to consider whether future refinements may be needed.

Some commenters expressed concern that practitioners who report E/M services in multiple settings (e.g. hospital inpatient, emergency department) would be required to document and create billing protocols under different rules depending on the setting. CMS will review and take into account these comments for consideration in possible future rulemaking.

Office/Outpatient E/M Visit Revaluation (CPT codes 99201-99215)

CMS finalized its proposal to adopt the RUC-recommended work RVUs for all of these E/M codes and the new prolonged services add-on code. CMS established separate values for Levels 2-4 office/outpatient E/M visits for both new and established patients rather than continue with the blended rate. CMS finalized its proposal to delete Level 1 new patient office/outpatient E/M visit code, 99201.

With payment changes to the E/M services, many specialties, including radiology, are impacted. Estimated combined impact to radiology is 8 percent reduction (Table 120). CMS plans to implement changes resulting changes to the E/M services starting January 1, 2021.

Table 34 from the final rule illustrates the surveyed times for each service period and the surveyed total time. It also shows the actual total time. CMS sought comments on which times should be used and how CMS should resolve differences between the component and total times when they conflict.

HCPCS Code	Pre-Service Time	Intra-Service Time	Immediate Post-Service Time	Actual Total Time	RUC-recommended Total Time
99202	2	15	3	20	22
99203	5	25	5	35	40
99204	10	40	10	60	60
99205	14	59	15	88	85
99211		5	2	7	7
99212	2	11	3	16	18
99213	5	20	5	30	30
99214	7	30	10	47	49
99215	10	45	15	70	70

Table 35 from the final rule shows a side-by-side comparison of work RVUs and physician time for the office/outpatient E/M services code set and the new prolonged services code.

HCPCS Code	Current Total Time (mins)	Current Work RVU	CY 2021 Total Time (mins)	CY 2021 Work RVU	RUC rec Total Time (mins)	RUC rec Work RVU
99201	17	0.48	17	0.48	N/A	N/A
99202	22	0.93	22	1.76	22	0.93
99203	29	1.42	29	1.76	40	1.6
99204	45	2.43	45	1.76	60	2.6
99205	67	3.17	67	3.17	85	3.5
99211	7	0.18	7	0.18	7	0.18
99212	16	0.48	16	1.18	18	0.7
99213	23	0.97	23	1.18	30	1.3
99214	40	1.5	40	1.18	49	1.92
99215	55	2.11	55	2.11	70	2.8
99XXX	N/A	N/A	N/A	N/A	15	0.61

CMS notes in the final rule that some commenters expressed concern with the RUC-recommended values and the survey process used to collect the data. These commenters urged CMS to delay implementation of the RUC-recommended values until the public is more familiar with the new coding system, at which time the codes could be resurveyed by the RUC. CMS responded that the RUC process and resultant recommendations provide a sufficient basis on which to set values for CY 2021, especially given that there is sufficient time to consider any additional information pertaining to valuation of these services if submitted prior to the February 10, 2020 deadline for submission of RUC and/or stakeholder valuation recommendations to be considered for CY 2021 rulemaking.

CMS also acknowledges the ACR’s concern about the redistributive impact of revaluing the office/outpatient E/M visit code set for practitioners who do not routinely bill E/M visits. The Agency indicated that they understand these concerns, but given that these revised codes and values do not take effect until CY 2021 and they do not know the magnitude of redistribution resulting from other policies that may be adopted through rulemaking before then, it was premature to finalize a strategy for mitigating the impacts in this final rule. CMS intends to consider these concerns and address them in future rulemaking.

Simplification, Consolidation and Revaluation of HCPCS codes GCG0X and GPC1X

CMS believes that there is still a need for add-on coding because the revised office/outpatient E/M code set does not recognize that there are additional resource costs inherent in providing some kinds of office/outpatient E/M visits. CMS finalized its proposal to delete GCG0X and for GPC1X, revise descriptor, increase value and allow it to be reported with all office/outpatient E/M visit levels.

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

CMS finalized its proposal to delete the extended visit code GPRO1 and adopt the new code, 99xxx. CMS accepted the RUC recommended values for this code without refinement.

Global Surgical Packages

The AMA RUC recommended adjusting the office/outpatient E/M visits for procedures with post-

operative visits included in 10- or 90-day global periods to reflect the changes made to the values for office/outpatient visits. CMS did not make this proposal due to outstanding questions regarding E/M services furnished as part of global surgery services.

Comment Solicitation on Opportunities for Bundled Payments under the MPFS (Page 854)

CMS states that identifying and developing appropriate payment policies that aim to achieve better care and improved health for Medicare beneficiaries is a priority for the agency. CMS is interested in exploring new options for establishing MPFS payment rates or adjustments for services that are provided together (bundled payment). CMS sought public comments on opportunities to expand the concept of bundling to recognize efficiencies among physicians' services paid under the MPFS and better align Medicare payment policies.

CMS received many comments in response to this solicitation. Some commenters expressed general support for the concept of bundled payments while urging caution on the design and implementation, suggesting that specialty societies and the CPT Editorial Panel are positioned to identify opportunities for bundled payments. Other commenters stated that bundled payments are not within the statutory authority of the PFS and suggested that CMS continue to use the Innovation Center to test these concepts. CMS indicated that they will consider these comments for future rulemaking.

Physician Supervision Requirements for Physician Assistants (PAs) (Page 365)

CMS received many comments to their CY 2018 request for information (RFI) regarding supervision requirements for PAs. Under the general supervision requirement, PAs services must be provided under a physician's overall direction; however, the physician does not have to be in the same room when the service is being provided. Commenters made the point that PAs are now practicing more autonomously, similar to nurse practitioners and clinical nurse specialists.

Based on comments received, for CY 2020, CMS proposed to revise the regulation that establishes physician supervision requirements for PAs. CMS proposed to make the revision so that statutory physician supervision requirement for PA services would be met when a PA provides their services in accordance with state law and the state scope of practice rules for the PAs in the state in which the services are provided, with medical direction and appropriate supervision as provided by state law in which the services are performed. 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 medical record of the PA's approach to working with physicians in providing their services. The CMS proposal mostly deferred to state law and state scope of practice and enables states the flexibility to develop requirements for PA services that are unique and appropriate for their respective state.

While commenters generally agreed with the proposal to align with state supervision laws, some commenters urged CMS to require that, in the absence of state law governing physician supervision of PA services, PAs should be required to document at the practice level, rather than in the medical record, the working relationship that they have with physicians. The commenters expressed concern that requiring PAs to document their approach in the medical record for every patient that they treat would be a tremendous administrative burden that would have a significantly adverse impact on the PA's ability to deliver care. Other commenters disagreed with the proposals in general and urged CMS to maintain the current regulatory standard for general physician supervision of PA services as a clearer standard for physician supervision across-the-board for the Medicare program, and consistent with statutory requirements.

After considering comments, CMS finalized the proposal to follow applicable state supervision laws. 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 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 physician/s when furnishing professional services.

Equipment Recommendations for Scope Systems (Page 52)

In their review of PE inputs, CMS has noticed inconsistencies with the use of scopes and video systems. In an effort to clarify the equipment inputs, CMS proposed standalone prices for each scope and separate prices of the video systems and associated accessories. The types of scopes (flexible, rigid, semi-rigid, etc.) and the scope video components (monitor, processor, printer, etc.) were defined and categorized.

The RUC organized a Scope Equipment Reorganization Workgroup to provide detailed recommendations to CMS for CY 2020, including 23 different types of scope equipment and associated invoices. Based on the RUC recommendation, CMS proposed to establish 23 new scope equipment codes. However, CMS only received invoices for pricing of 8 of the 23 new codes. CMS proposed to transition the scopes for which they did have pricing information over to the new equipment items for CY 2020, and noted that they looked forward to engaging with stakeholders to assist in pricing and then transitioning the remaining scopes in future rulemaking. In response to the proposed rule, CMS received invoices for an additional 7 pieces of equipment and finalized pricing for those pieces as well as the 8 previously proposed equipment prices.

Practice Expense Methodology

Equipment Utilization Rate Assumption (Page 42)

CMS proposed to keep the rate at 50 percent for the majority of equipment and 90 percent for expensive diagnostic imaging equipment as required by law. CMS received a comment from a stakeholder recognizing that the 90 percent equipment utilization is mandated, however the commenter indicated that it is not realistic in a typical outpatient imaging setting. CMS disagreed with the commenter and stated that they continue to believe that certain highly technical pieces of equipment and equipment rooms are less likely to be used during all of the preservice or postservice tasks performed by clinical labor staff on the day of the procedure and are typically available for other patients even when one member of clinical staff may be occupied with a preservice or postservice task related to the procedure.

Equipment Maintenance (Page 44)

The current annual equipment maintenance factor is at 5 percent. CMS does not believe that this is an accurate rate for all equipment. CMS does not believe that voluntary submissions of maintenance costs of individual equipment items is appropriate methodology for determining costs. Unless they come across publicly available datasets or another systematic data collection methodology, CMS will maintain the current annual maintenance factor.

Interest Rates (Page 45)

The interest rate is based on the Small Business Administration (SBA) maximum interest rates for different categories of loan size, equipment cost, and maturity, useful life. CMS did not make any proposals to change the interest rates used in developing the equipment cost per minute calculation for CY 2020.

CMS received a comment stating that the 2012 SBA maximum interest rates are significantly lower than the 2019 rates. The commenter stated that CMS should also update the interest rates used to calculate PE RVUs for such items based on current SBA data. CMS responded that they will consider potential changes to the interest rates used in the equipment cost per minute calculation for possible future rulemaking.

Changes to Direct PE Inputs for Specific Services

Standardization of Clinical Labor Tasks (Page 46)

In their efforts to be more transparent, CMS continues to work on revisions to the direct practice expense input database to provide the number of clinical labor minutes assigned for each task for every code in the database instead of minutes associated with pre, intra and post service periods for each code. The direct PE inputs are included in the CY 2020 direct PE input public use files, which are available on the CMS website under downloads for the CY 2020 PFS final rule at

<http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html>.

Updates to Prices for Existing Direct PE Inputs (Page 80)

In order for invoices to be included in a given year's proposed rule, CMS needs to receive them by February 10th deadline in 2020. However, CMS will consider invoices submitted during the proposed rule comment period or during other times as part of its annual process.

Market-Based Supply and Equipment Pricing Update (Page 80)

For CY2019, CMS contracted with StrategyGen to review and update the pricing for direct practice expense supply and equipment inputs. This yielded a report with pricing recommendations for approximately 1300 supply and 750 equipment items. While StrategyGen's findings indicated that the average commercial price for these inputs have remained relatively stable, some medical specialties would experience increases or decreases in their Medicare payments if the changes were adopted. For this reason, a four-year phase in of the new pricing was proposed.

CMS received many comments following their CY2019 proposed rule, with many concerns about the accuracy of the supply and equipments' updated pricing. For those items, StrategyGen conducted further research to confirm that the pricing was appropriate. Submitted invoices were also accepted for review and consideration. Following this additional review, approximately 70 supply and equipment items had their prices further updated. Two of those items include the ultrasound room and the vascular ultrasound room, which both yielded a higher price than previously recommended by StrategyGen. CMS finalized the proposed new pricing for the ultrasound room of \$410,303.32, increased from \$369,945.00. CMS also finalized the proposed new pricing for the vascular ultrasound room of \$479,753.32, increased from \$466,492.00. Updated supply and equipment pricing as it will be implemented over the 4-year transition period is available at: <http://www.cms.gov/medicare/medicare->

[fee-for-service-payment/physicianfeesched/pfs-federal-regulation-notice.html](https://www.cms.gov/fee-for-service-payment/physicianfeesched/pfs-federal-regulation-notice.html).

The ACR raised concerns with regard to the pricing of the PET-CT room equipment going from \$2,136,283 to \$206,326. CMS responded that in the absence of invoices or other pricing data, they believe that their proposed pricing is based on the most accurate source of data. The ACR will continue to work with CMS to determine whether this price was a typographical error in the StrategyGen report.

Potentially Misvalued Services Under the PFS (Page 165)

CMS is required to periodically identify codes that are potentially misvalued based on certain criteria, such as changes in practice expense, fast growth, codes frequently billed together, or codes that haven't been recently reviewed. The RUC may also identify potential codes for review, and publically nominated codes from individuals or stakeholders are also considered.

CMS received three submissions nominating codes for review. Additionally, CMS also nominated a code for review as potentially misvalued. Of these, two of the codes pertain to radiology.

Two codes in the Fine Needle Aspiration code family were publicly nominated as potentially misvalued. CPT codes 10005 (*Fine needle aspiration biopsy, including ultrasound guidance; first lesion*) was nominated along with 10021 (*Fine needle aspiration biopsy, without imaging guidance; first lesion*) due to the commenter's discomfort with the ratio of time to RVU for these specific procedures. CMS indicated in the final rule that they did not receive any additional information to consider in the context of their previous review of these services. Therefore, the Agency did not include the Fine Needle Aspiration codes on the final list of potentially misvalued codes for CY 2020.

CMS nominated CPT code 76377 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image post-processing under concurrent supervision; requiring image post-processing on an independent workstation*) as potentially valued as it has not been recently reviewed. CPT code 76376 was recently reviewed at the April 2018 RUC meeting. The Rule states that due to these codes' similarities, CPT code 76377 should be reviewed in order to maintain relativity in the code family. Despite comments from the ACR indicating that CPT code 76377 is different in scope from CPT code 76376, CMS finalized its inclusion as a potentially misvalued code for CY 2020.

Valuation of Specific Codes for CY 2020 (Page 473)

Bone Biopsy Trocar-Needle (CPT codes 20220 and 20225) (Page 514)

CPT code 20225 (*Biopsy, bone, trocar, or needle; deep (eg, vertebral body, femur)*) was identified as being performed by a different specialty than the one that originally surveyed it. CPT code 20220 was included as part of the family and both codes were surveyed for CY 2020.

In the proposed rule, CMS disagreed with the RUC-recommended 1.93 RVU for CPT code 20220. CMS proposed a crosswalk to CPT code 47000 (*Biopsy of liver, needle; percutaneous*) at 1.65 RVU, given their identical intraservice times.

For CPT code 20225, CMS proposed to crosswalk to CPT code 30906 (*Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent*), resulting in a work RVU of 2.45, which is lower than the RUC-recommended 3.00 RVU. CPT code 30906 has the same intraservice time and similar total time.

In the proposed rule, CMS proposed to replace the bone biopsy device (SF055) supply with the bone biopsy needle (SC077) in CPT code 20225. The bone biopsy needle is the current supply input for CPT code 20225 and no rationale was provided to support the change to the bone biopsy device. CMS also proposed to adopt a 90 percent utilization rate for the CT room (EL007) in CPT code 20225.

In the final rule, CMS acknowledged commenters' feedback that bone biopsy code 20220 is more intense than their proposed liver biopsy crosswalk code, 47000. However, they indicated that the RUC-recommended value for CPT code 20220 would have yielded a much higher intensity. **CMS finalized 1.65 RVU for CPT code 20220.**

In the final rule, CMS disagreed with commenters who stated that it was inappropriate to crosswalk bone biopsy code 20225 to CPT code 30906, which describes a nosebleed procedure. Citing the similar times and intensities of both procedures, as well as the clinical work involved, **finalized 2.45 RVU for CPT code 20225.**

CMS disagreed with commenters who indicated that it was invalid to compare the current time and work to the surveyed time and work, stating that using existing values as a point of comparison plays an important role in PFS ratesetting and is critical to the integrity of the relative value system.

While they appreciated the additional information regarding the bone biopsy device, CMS does not agree that it is typically used to perform CPT code 20225. Given that a bone biopsy needle has the typical input for the past 15 years, CMS stated that a rationale was not provided to justify the change to the bone biopsy device. **CMS believes that the typical input for CPT code 20225 remains the bone biopsy needle.**

Pericardiocentesis and Pericardial Drainage (CPT codes 33016, 33017, 33018, and 33019) (Page 544)

CPT code 33015 (*Tube pericardiostomy*) was identified as potentially misvalued on a screen of codes with a negative IWPUR and Medicare utilization over 10,000 for all services or over 1,000 for Harvard and CMS/Other codes. The CPT Editorial panel then deleted four codes and created four new codes to describe pericardiocentesis drainage procedures, differentiating by age and to include imaging.

In the proposed rule, CMS proposed refinements to the values for all four codes in the family. CMS proposed a crosswalk methodology to value the codes, based largely on similar procedure times. CMS proposed to crosswalk CPT code 33016 (*Pericardiocentesis, including imaging guidance, when performed*) to CPT code 43244 (*Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices*) at 4.40 RVU and CPT code 33017 (*Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; 6 years and older without congenital cardiac anomaly*) to CPT code 52234 (*Cystourethroscopy, with fulguration (including cryosurgery or laser surgery) and/or resection of; SMALL bladder tumor(s) (0.5 up to 2.0 cm)*) at 4.62 RVU. For CPT codes 33018 (*Pericardial drainage with insertion of indwelling catheter, percutaneous, including fluoroscopy and/or ultrasound guidance, when performed; birth through 5 years of age, or any age with congenital cardiac anomaly*), and 33019 (*Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT guidance*), CMS proposed the survey 25th percentile values, at 5.00 RVU and 4.29 RVU, respectively.

In the final rule, CMS disagreed with commenters about the inappropriateness of the crosswalks that were proposed for CPT codes 33016 and 33017. CMS believes that their proposed values appropriately

capture the intensities of these procedures relative to the comparator codes, as well as the larger physician fee schedule. **CMS finalized 4.40 RVU for CPT code 33016 and 4.62 RVU for CPT code 33017.**

CMS agreed with commenters that the CPT code 33018 is a more intense procedure than CPT code 33016, which is not reflected in CMS's proposed values. **CMS refined their initial proposed value for CPT code 33018 and finalized a work RVU of 5.40 (an increase over the proposed 5.00 RVU).**

CMS disagreed with commenters that CPT code 33016 and 33019 have identical work, stating that the survey data clearly demonstrates that CPT code 33019 should be valued less than CPT code 33016. **CMS finalized 4.29 RVU for CPT code 33019.**

Intravascular Ultrasound (CPT codes 37252 and 37253) (Page 571)

CPT codes 37252 (*Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; initial noncoronary vessel*) and 37253 (*Intravascular ultrasound (noncoronary vessel) during diagnostic evaluation and/or therapeutic intervention, including radiological supervision and interpretation; each additional noncoronary vessel*) were initially addressed by the RUC in January 2015. The codes were brought back to the RUC in October 2018 due to the unexpected increase in utilization. The survey data supported the times and RVUs for CPT code 37252 and 37253 despite the underestimation in utilization.

In the proposed rule, CMS disagreed with the RUC-recommendations for CPT codes 37252 and 37253. CMS proposed to crosswalk CPT code 37252 to CPT code 19084 (*Biopsy, breast, with placement of breast localization device(s) (eg, clip, metallic pellet), when performed, and imaging of the biopsy specimen, when performed, percutaneous; each additional lesion, including ultrasound guidance (List separately in addition to code for primary procedure)*) at 1.55 RVU, and applied the 0.36 RVU interval to value CPT code 37253 at 1.19 RVU.

CMS proposed these values to restore work neutrality to the intravascular ultrasound code family to achieve the savings they had initially anticipated when these codes were first created and valued.

In the final rule, CMS acknowledged commenters who stated that reducing work RVUs to achieve budget neutrality may not be appropriate and that the valuation of these codes should be determined irrespective of utilization. **CMS refined their initial proposed values and finalized the RUC-recommended 1.80 RVU for CPT code 37252 and 1.44 RVU for CPT code 37253.**

Stab Phlebectomy of Varicose Veins (CPT codes 37765 and 37766) (Page 574)

CPT codes 37765 (*Stab phlebectomy of varicose veins, 1 extremity; 10-20 stab incisions*) and 37766 (*Stab phlebectomy of varicose veins, 1 extremity; more than 20 incisions*) were identified on the High Volume Growth screen for services with Medicare utilization over 1,000 that have increased by at least 100 percent from 2004 to 2006. These codes were surveyed in April 2018 and the RUC recommended 4.80 RVU for CPT code 37765 and 6.00 RVU for CPT code 37766. In the proposed rule, CMS agreed with the RUC recommendations.

In the final rule, CMS received some comments that suggested that the RUC-recommended physician survey times were inaccurate and that the proposed values will result in payment reductions. CMS indicates that they support the RUC valuations, stating that they believe the RUC-recommended work

RVU decreases are in proportion to the reduction in survey work time. However, CMS welcomes any additional data or information that would allow them to consider these codes for further review in the future. **CMS finalized 4.80 RVU for CPT code 37765 and 6.00 RVU for CPT code 37766.**

Lumbar Puncture (CPT codes 62270, 62328, 62272, and 62329) (Page 593)

CPT codes 62270 (*Spinal puncture, lumbar, diagnostic*) and 622X0 (*Spinal puncture, lumbar, diagnostic; with fluoroscopic or CT guidance*) describe diagnostic lumbar puncture procedures, while CPT codes 62272 (*Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter)*) and 622X1 (*Spinal puncture, therapeutic, for drainage of cerebrospinal fluid (by needle or catheter); with fluoroscopic or CT guidance*) describe therapeutic lumbar puncture procedures. Both 62270 and 62272 describe procedures without imaging, while 622X0 and 622X1 bundle the lumbar puncture procedure with fluoroscopic or CT imaging guidance.

In the proposed rule, CMS disagreed with the RUC-recommended values for all four codes. CMS proposed to crosswalk CPT code 62270 to CPT code 40490 (*Biopsy of lip*) at 1.22 RVU, citing identical intraservice times and similar total times. CMS then applied interval increases to value the remaining three codes at 1.73 RVU for CPT code 62328, 1.58 RVU for CPT code 62272, and 2.03 RVU for CPT code 62329.

In the final rule, CMS responded to commenters who suggested that CPT code 40490 was an inappropriate comparator code for CPT code 62270 based on their clinical differences, patient populations, and the differences in intensities and complexities between the procedures. CMS states that the nature of the PFS relative value system allows for all codes to be appropriately subject to comparisons to one another, and that codes don't always have to share the same site of service, patient population, or utilization level in order to serve as an appropriate crosswalk. CMS further countered comments suggesting that applying an incremental approach to value procedure codes is inappropriate. **CMS finalized 1.22 RVU for CPT code 62270, 1.73 RVU for CPT code 62328, 1.58 RVU for CPT code 62272, and 2.03 RVU for CPT code 62329.**

X-Ray Exam - Sinuses (CPT codes 70210 and 70220) (Page 638)

CPT codes 70210 (*Radiologic examination, sinuses, paranasal, less than 3 views*) and 70220 (*Radiologic examination, sinuses, paranasal, complete, minimum of 3 views*) were identified on a CMS/Other screen for codes with utilization greater than 30,000.

In the proposed rule, CMS disagreed with the RUC-recommended 0.20 RVU for CPT code 70210, which is a slight increase over the existing value of 0.17, citing comparisons to CPT codes 71046 (*Radiologic examination, chest; 2 views*) and 70355 (*Orthopantomogram (eg, panoramic x-ray)*), which have similar times and RVUs. CMS proposed to maintain the current 0.17 RVU for CPT code 70210. CMS agreed with the RUC-recommended 0.22 RVU for CPT code 70220.

In the final rule, CMS addressed commenters' concern about the validity of CMS/Other times and their use in code valuation, stating that the validity of existing times should be assumed and is critical in the relativity value system. **CMS finalized 0.17 RVU for CPT code 70210 and 0.22 RVU for CPT code 70220.**

X-Ray Exam - Skull (CPT codes 70250 and 70260) (Page 641)

CPT code 70250 (*Radiologic examination, skull, less than 4 views*) was identified on a CMS/Other

screen for codes with utilization greater than 30,000. CPT code 70260 (*Radiologic examination, skull; complete, minimum of 4 views*) was surveyed as part of the family.

In the proposed rule, CMS disagreed with the RUC-recommendations for CPT codes 70250 and 70260. Citing a decrease in procedure times, CMS proposed 0.18 RVU for CPT code 70250 and applied an incremental approach to recommend 0.28 RVU for CPT code 70260.

In the final rule, CMS addressed commenters' concern about the validity of CMS/Other times and their use in code valuation, stating that the validity of existing times should be assumed and is critical in the relativity value system. CMS further countered comments suggesting that applying an incremental approach to value procedure codes is inappropriate. **CMS finalized 0.18 RVU for CPT code 70250 and 0.28 RVU for CPT code 70260.**

X-Ray Exam - Neck (CPT code 70360) (Page 645)

CPT code 70360 (*Radiologic examination; neck, soft tissue*) was identified on a CMS/Other screen for codes with utilization greater than 30,000.

In the proposed rule, CMS disagreed with the RUC-recommended 0.20 RVU for CPT code 70360, citing the unchanged total time for the procedure and insufficient support for the increase in work RVU. CMS proposed 0.18 RVU based on a crosswalk to CPT code 73552 (*Radiologic examination, hips, bilateral, with pelvis when performed; 3-4 views*), which has identical times.

In the final rule, CMS addressed commenters' concern about the validity of CMS/Other times and their use in code valuation, stating that the validity of existing times should be assumed and is critical in the relativity value system. **CMS finalized 0.18 RVU for CPT code 70360.**

X-Ray Exam - Spine (CPT codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, and 72120) (Page 648)

CPT codes 72020 (*Radiologic examination spine, single view, specify level*) and 72072 (*Radiologic examination, spine; thoracic, 3 views*) were identified on a CMS/Other screen for codes with utilization greater than 100,000. The family was expanded to include CPT codes 72040 (*Radiologic examination, spine, cervical; 2 or 3 views*), 72050 (*Radiologic examination, spine, cervical; 4 or 5 views*), 72052 (*Radiologic examination, spine cervical; 6 or more views*), 72070 (*Radiologic examination spine; thoracic, 2 views*), 72074 (*Radiologic examination, spine; thoracic, minimum of 4 views*), 72080 (*Radiologic examination, spine; thoracolumbar junction, minimum of 2 views*), 72100 (*Radiologic examination, spine, lumbosacral; 2 or 3 views*), 72110 (*Radiologic examination, spine, lumbosacral; minimum of 4 views*), 72114 (*Radiologic examination, spine, lumbosacral; complete, including bending views, minimum of 6 views*), and 72120 (*Radiologic examination, spine, lumbosacral; bending views only, 2 or 3 views*).

In the proposed rule, CMS agreed with the RUC-recommended values for all 12 codes in the x-ray of the spine family. The values are as follows: 0.16 RVU for CPT code 72020, 0.22 RVU for CPT code 72040, 0.27 RVU for CPT code 72050, 0.30 RVU for CPT code 72052, 0.20 RVU for 72070, 0.23 RVU for CPT code 72072, 0.25 RVU for CPT code 72074, 0.21 RVU for CPT code 72080, 0.22 RVU for CPT code 72100, 0.26 RVU for CPT code 72110, 0.30 RVU for CPT code 72114, and 0.22 RVU for CPT code 72120. The values are either identical or very similar to their current values.

In the final rule, **CMS finalized the RUC-recommended values for all 12 x-ray spine codes.**

CT-Orbit-Ear-Fossa (CPT codes 70480, 70481, and 70482) (Page 649)

CPT code 70480 (*Computed tomography (CT), orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material*) was identified on a CMS/Other screen for codes with utilization greater than 30,000. The family was expanded to include CPT codes 70481 (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; with contrast material*) and 70482 (*Computed tomography, orbit, sella, or posterior fossa or outer, middle, or inner ear; without contrast material followed by contrast material(s) and further sections*).

In the proposed rule, CMS disagreed with the RUC-recommendations for CPT codes 70480 and 70481, citing decreases in the procedure work time. CMS proposed 1.13 RVU for CPT code 70480 and 1.06 RVU for CPT code 70481. CMS accepted the RUC-recommended 1.27 RVU for CPT code 70482.

In the final rule, CMS acknowledged comments that the CT orbit-ear-fossa codes does not reflect the typical step-up in time and work as in most radiology code families, and that the RUC-recommended values fell at or below the survey 25th percentile. **CMS has refined their initial proposed values and finalized the RUC-recommended 1.28 RVU for CPT code 70480 and 1.13 RVU for CPT code 70481. CMS is finalizing 1.27 RVU for CPT code 70482.**

CT Spine (CPT codes 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, and 72133) (Page 652)

CPT code 72132 (*Computed tomography, lumbar spine; with contrast material*) was identified on a CMS/Other screen for codes with utilization greater than 30,000. The family was expanded to include CPT codes 72125 (*Computed tomography, cervical spine; without contrast material*), 72126 (*Computed tomography, cervical spine; with contrast material*), 72127 (*Computed tomography, cervical spine; without contrast material, followed by contrast material(s) and further sections*), 72128 (*Computed tomography, thoracic spine; without contrast material*), 72129 (*Computed tomography, thoracic spine; with contrast material*), 72130 (*Computed tomography, thoracic spine; without contrast material, followed by contrast material(s) and further sections*), 72131 (*Computed tomography, lumbar spine; without contrast material*), and 72133 (*Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections*).

In the proposed rule, CMS agreed with the RUC-recommended values for eight of the nine codes in the family. The values for those eight codes are as follows: 1.22 RVU for CPT code 72126, 1.27 RVU for CPT code 72127, 1.00 RVU for CPT code 72128, 1.22 RVU for CPT code 72129, 1.27 RVU for CPT code 72130, 1.00 RVU for CPT code 72131, 1.22 RVU for CPT code 72132, and 1.27 RVU for CPT code 72133.

For CPT code 72125, CMS proposed 1.00 RVU, consistent with the other non-contrast codes in the family. The RUC-recommended 1.07 RVU for this code was based on the increased intensity and complexity of the cervical spine but CMS stated that this was not reflected in the survey times, which are identical to the other non-contrast procedures.

In the final rule, CMS disagreed with commenters who suggested that CPT code 72125 is a more complex and intense procedure than CPT codes 72128 and 72131, stating that the survey data and physician times did not support this position. CMS also addressed comments that implied that the CT equipment times were inaccurate. **CMS finalized 1.00 RVU for CPT code 72125, 1.22 RVU for CPT code 72126, 1.27 RVU for CPT code 72127, 1.00 RVU for CPT code 72128, 1.22 RVU for CPT**

code 72129, 1.27 RVU for CPT code 72130, 1.00 RVU for CPT code 72131, 1.22 RVU for CPT code 72132, and 1.27 RVU for CPT code 72133.

X-Ray Exam - Pelvis (CPT codes 72170 and 72190) (Page 658)

CPT code 72190 (*Radiologic examination, pelvis; complete, minimum of 3 views*) was identified on a CMS/Other screen for codes with utilization greater than 30,000. The family was expanded to include CPT code 72170 (*Radiologic examination, pelvis; 1 or 2 views*).

In the proposed rule, CMS accepted the RUC-recommended values for both codes: 0.17 RVU, the existing value, for CPT code 72170 and 0.25 RVU, slightly higher than existing value, for CPT code 72190.

In the final rule, **CMS finalized the RUC-recommended values for both x-ray pelvis codes.**

X-Ray Exam - Sacrum (CPT codes 72200, 72202, and 72220) (Page 659)

CPT code 72220 (*Radiologic examination, sacrum and coccyx, minimum of 2 views*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 100,000. The family was expanded to include CPT codes 72200 (*Radiologic examination, sacroiliac joints; less than 3 views*) and 72202 (*Radiologic examination, sacroiliac joints; 3 or more views*).

In the proposed rule, CMS disagreed with the RUC-recommended values for all three codes in the family, which were all higher than the existing values. CMS proposed to maintain the current values of 0.17 RVU for CPT code 72200 and 0.17 RVU for CPT code 72220. For CPT code 72202, CMS applied an incremental increase to propose 0.23 RVU.

In the final rule, CMS addressed commenters' concern about the validity of CMS/Other times and their use in code valuation, stating that the validity of existing times should be assumed and is critical in the relativity value system. CMS further countered comments suggesting that applying an incremental approach to value procedure codes is inappropriate. **CMS finalized 0.17 RVU for CPT code 72200, 0.23 RVU for CPT code 72202, and 0.17 RVU for CPT code 72220.**

X-Ray Exam – Clavicle-Shoulder (CPT codes 73000, 73010, 73020, 73030, and 73050) (Page 665)

CPT code 73030 (*Radiologic examination, shoulder; complete, minimum of 2 views*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 100,000. The family was expanded to include CPT codes 73000 (*Radiologic examination; clavicle, complete*), 73010 (*Radiologic examination; scapula, complete*), 73020 (*Radiologic examination, shoulder; 1 view*), and 73050 (*Radiologic examination, acromioclavicular joints, bilateral, with or without weighted distraction*).

In the proposed rule, CMS accepted the RUC-recommended values for all five codes in the family: 0.16 RVU for CPT code 73000, 0.17 RVU for CPT code 73010, 0.15 RVU for CPT code 73020, 0.18 RVU for CPT code 73030, and 0.18 RVU for CPT code 73050.

In the final rule, **CMS finalized the RUC-recommended values for all five x-ray of the clavicle-shoulder codes.**

CT Lower Extremity (CPT codes 73700, 73701, and 73702) (Page 666)

CPT code 73701 (*Computed tomography, lower extremity; with contrast material(s)*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000. The family was expanded to include 73700 (*Computed tomography, lower extremity; without contrast material*) and 73702 (*Computed tomography, lower extremity; without contrast material, followed by contrast material(s) and further sections*).

In the proposed rule, CMS accepted the RUC-recommended values for all three codes in the family: 1.00 RVU for CPT code 73700, 1.16 RVU for CPT code 73701, and 1.22 RVU for CPT code 73702.

In the final rule, **CMS finalized the RUC-recommended values for all three CT lower extremity codes.** CMS also addressed comments that implied that the CT equipment times were inaccurate.

X-Ray Elbow-Forearm (CPT codes 73070, 73080, and 73090) (Page 667)

CPT codes 73070 (*Radiologic examination, elbow; 2 views*) and 73090 (*Radiologic examination; forearm, 2 views*) were identified on a CMS/Other screen for codes with Medicare utilization greater than 100,000. The family was expanded to include CPT code 73080 (*Radiologic examination, elbow; complete, minimum of 3 views*).

In the proposed rule, CMS accepted the RUC-recommended values for all three codes in the family: 0.16 RVU for CPT code 73070, 0.17 RVU for CPT code 73080, and 0.16 RVU for CPT code 73090.

In the final rule, **CMS finalized the RUC-recommended values for all three x-ray elbow-forearm codes.**

X-Ray Heel (CPT code 73650) (Page 668)

CPT code 73650 (*Radiologic examination; calcaneous, minimum of 2 views*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 100,000.

In the proposed rule, CMS accepted the RUC-recommended value of 0.16 RVU for CPT code 73650.

In the final rule, **CMS finalized the RUC-recommended value of 0.16 RVU for CPT code 73650.**

X-Ray Toe (CPT code 73660) (Page 669)

CPT code 73660 (*Radiologic examination; toe(s), minimum of 2 views*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 100,000.

In the proposed rule, CMS accepted the RUC-recommended value of 0.13 RVU for CPT code 73660.

In the final rule, **CMS finalized the RUC-recommended value of 0.13 RVU for CPT code 73660.**

Upper Gastrointestinal Tract Imaging (CPT Codes 74210, 74220, 74230, 74221, 74240, 74246, and 74248) (Page 669)

These codes were identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000. The family was referred to the CPT Panel, which revised the code set to conform to other

families of x-ray codes. The code family includes CPT codes 74210 (*Radiologic examination, pharynx and/or cervical esophagus, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study*), 74220 (*Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*), 74230 (*Radiologic examination, swallowing function, with cineradiography/ videoradiography, including scout neck radiograph(s) and delayed image(s), when performed, contrast (eg, barium) study*), 74240 (*Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*), 74246 (*Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study, including glucagon, when administered*), and two new codes, 74221 (*Radiologic examination, esophagus, including scout chest radiograph(s) and delayed image(s), when performed; double-contrast (eg, high-density barium and effervescent agent) study*), and 74248 (*Radiologic examination, upper gastrointestinal tract, including scout abdominal radiograph(s) and delayed image(s), when performed; with small intestine follow-through study, including multiple serial images (List separately in addition to code for primary procedure)*).

In the proposed rule, CMS accepted the RUC-recommended values for all of the codes in the family: 0.59 RVU for CPT code 74210, 0.60 RVU for CPT code 74220, 0.70 RVU for CPT code 74221, 0.53 RVU for CPT code 74230, 0.80 RVU for CPT code 74240, 0.90 RVU for CPT code 74246, and 0.70 RVU for CPT code 74248.

In the proposed rule, CMS proposed refinements to the RUC-approved practice expense inputs. CMS requested feedback to support the recommended minutes allotted to the “Perform procedure/service – NOT directly related to physician work” activity for CPT codes 74210, 74220, 74221, 74230, 74240, and 74246. CMS also proposed to refine the minutes for “Prepare room, equipment and supplies” and “Prepare, set-up and start IV, initial positioning and monitoring of patient” to the standard 2 minutes, which impacts the equipment time calculations.

In the final rule, **CMS finalized the RUC-recommended value for all seven upper gastrointestinal tract imaging codes.** CMS also thanked commenters for clarifying the minutes requested for the clinical staff activities. Upon further consideration, **CMS finalized the RUC-recommended direct PE inputs.**

Lower Gastrointestinal Tract Imaging (CPT Codes 74250, 74251, 74270, and 74280) (Page 672)

These codes were identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000. The family includes CPT codes 74250 (*Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; single-contrast (eg, barium) study*), 74251 (*Radiologic examination, small intestine, including multiple serial images and scout abdominal radiograph(s), when performed; double-contrast (eg, high-density barium and air via enteroclysis tube) study, including glucagon, when administered*), 74270 (*Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; single-contrast (eg, barium) study*), and 74280 (*Radiologic examination, colon, including scout abdominal radiograph(s) and delayed image(s), when performed; double-contrast (eg, high density barium and air) study, including glucagon, when administered*).

In the proposed rule, CMS accepted the RUC-recommended values for all of the codes in the family: 0.81 RVU for CPT code 74250, 1.17 for CPT code 74251, 1.04 for CPT code 74270, and 1.26 RVU for CPT code 74280.

In the proposed rule, CMS proposed refinements to the RUC-approved practice expense inputs. CMS requested feedback to support the recommended minutes allotted to the “Perform procedure/service – NOT directly related to physician work” activity for each of the codes. CMS also proposed to refine the equipment time for the room, radiographic-fluoroscopic for CPT code 74250 to conform to the highly technical equipment calculation.

In the final rule, **CMS finalized the RUC-recommended value for all four lower gastrointestinal tract imaging codes.** CMS also thanked commenters for clarifying the minutes requested for the clinical staff activities. Upon further consideration, **CMS finalized the RUC-recommended direct PE inputs.**

Urography (CPT Code 74425) (Page 674)

The physician time and work for CPT code 74425 (*Urography, antegrade (pyelostogram, nephrostogram, loopogram), radiological supervision and interpretation*) was combined with services describing genitourinary procedures in 2016. At the time, the RUC decided not to delete the code, and to wait for two years of Medicare claims data before resurveying, so as to distinguish the work of the service separately from the genitourinary procedures.

In the proposed rule, CMS accepted the RUC-recommended 0.51 RVU.

In the final rule, **CMS finalized the RUC-recommended 0.51 RVU for CPT code 74425.**

Abdominal Aortography (CPT Codes 75625 and 75630) (Page 675)

CPT codes 75625 (*Aortography, abdominal, by serialography, radiological supervision and interpretation*) and 75630 (*Aortography, abdominal plus bilateral iliofemoral lower extremity, catheter, by serialography, radiological supervision and interpretation*) were identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000.

In the proposed rule, CMS disagreed with the RUC-recommended 1.75 RVU for CPT code 75625, stating that it appears overvalued when compared to the key reference service, CPT code 75710 (*Angiography, extremity, unilateral, radiological supervision and interpretation*). CMS performed time ratio calculations between CPT code 75625 and 75710 to determine an appropriate RVU range and, using CPT code 38222 (*Diagnostic bone marrow; biopsy(ies) and aspiration(s)*) as a crosswalk, proposed a value of 1.44 RVU.

In the proposed rule, CMS accepted the RUC-recommended 2.00 RVU for CPT code 75630.

In the final rule, CMS addressed commenters’ concern about the validity of CMS/Other times and their use in code valuation, stating that the validity of existing times should be assumed and is critical in the relativity value system. CMS clarified that while they believe the survey data for CPT code 75625 support an increase in value, their analysis did not support an increase of the magnitude recommended by the RUC. **CMS finalized 1.44 RVU for CPT code 75625 and 2.00 RVU for CPT code 75630.**

Angiography (CPT Codes 75726 and 75774) (Page 678)

CPT codes 75726 (*Angiography, visceral, selective or supraseductive (with or without flush aortogram), radiological supervision and interpretation*) and 75774 (*Angiography, selective, each*

additional vessel studied after basic examination, radiological supervision and interpretation (List separately in addition to code for primary procedure) were identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000.

In the proposed rule, CMS accepted the RUC-recommended value for both codes: 2.05 for CPT code 75726 and 1.01 RVU for CPT code 75774.

In the final rule, **CMS finalized the RUC-recommended 2.05 RVU for CPT code 75726 and 1.01 RVU for CPT code 75774.**

X-Ray Specimen (CPT Code 76098) (Page 679)

CPT code 76098 (*Radiologic examination, surgical specimen*) was presented at the April 2018 meeting, during which time the specialty expressed concern about the appropriateness of a codes valuation process in which physician time and intensity for a code are reduced to account for overlap with codes that are furnished to a patient on the same day.

In the proposed rule, CMS requested feedback on parameters that might be used to indicate when codes that are furnished concurrently by the same provider should be valued to account for overlap in physician work time, intensity, and practice expense.

In the proposed rule, CMS accepted the RUC-recommended 0.31 RVU for CPT code 76098.

In the final rule, CMS clarified how CPT code 76098 came up for review by the RUC and noted the commenter's concern regarding the analysis of billed together data. **CMS finalized the RUC-recommended 0.31 RVU for CPT code 76098.**

3D Rendering (CPT Codes 76376) (Page 682)

CPT code 76376 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation*) was identified on a screen for codes with a negative intraservice work per unit of time (IWPUT) with 2016 estimated Medicare utilization greater than 10,000 for RUC reviewed codes and over 1,000 for Harvard or CMS/Other codes.

In the proposed rule, CMS accepted the RUC-recommended 0.20 RVU for CPT code 76376.

In the final rule, **CMS finalized the RUC-recommended 0.20 RVU for CPT code 76376.**

Ultrasound Exam – Chest (CPT Code 76604) (Page 683)

CPT code 76604 (*Ultrasound, chest (includes mediastinum), real time with image documentation*) was identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000.

In the proposed rule, CMS accepted the RUC-recommended 0.59 RVU for CPT code 76604.

In the final rule, CMS addressed commenters' concern about the ultrasound room being replaced by a portable ultrasound unit in the practice expense. CMS indicated that practice patterns have changed and, due to the high quality of portable ultrasound equipment now available, patients are typically

treated using portable ultrasounds instead of requiring the use of a full ultrasound room. **CMS finalized the RUC-recommended 0.59 RVU for CPT code 76604.**

X-Ray Exam - Bone (CPT Codes 77073, 77074, 77075, 77076, and 77077) (Page 684)

CPT codes 77073 (*Bone length studies (orthoroentgenogram, scanogram)*), 77075 (*Radiologic examination, osseous survey; complete (axial and appendicular skeleton)*), and 77077 (*Joint survey, single view, 2 or more joints*) were identified on a CMS/Other screen for codes with Medicare utilization greater than 30,000. The family was expanded to include CPT codes 77074 (*Radiologic examination, osseous survey; limited (eg, for metastases)*) and 77076 (*Radiologic examination, osseous survey, infant*).

In the proposed rule, CMS accepted the RUC-recommended values: 0.26 RVU for CPT code 77073, 0.44 RVU for CPT code 77074, 0.55 RVU for CPT code 77075, 0.70 RVU for CPT code 77076, and 0.33 RVU for CPT code 77077.

In the final rule, **CMS finalized the RUC-recommended values for all five x-ray bone codes.**

SPECT-CT Procedures (CPT Codes 78800, 78801, 78802, 78803, 78804, 78830, 78831, 78832, and 78835) (Page 685)

The CPT Editorial Panel restructured this family to better differentiate between planar radiopharmaceutical localization procedures and SPECT, SPECT-CT, and multiple area or multiple day radiopharmaceutical localization/distribution procedures by revising five codes, creating four new codes, and deleting nine existing codes.

In the proposed rule, CMS disagreed with the RUC-recommended values for all nine codes in the family. CMS applied a time-to-value ratio calculation to propose a value of 0.64 RVU 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 (eg, head, neck, chest pelvis), single day of imaging*). An incremental approach, the current value, or a ratio-based calculation was applied to value the other codes in the family: 0.73 RVU 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 (eg, abdomen and pelvis, head and chest), 1 or more days of imaging or single area imaging over 2 or more days*), 0.80 RVU 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*), 1.09 RVU 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 (eg, head, neck, chest pelvis), single day of imaging*), 1.01 RVU 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); planar, whole body, requiring 2 or more days of imaging*), 1.49 RVU for CPT code 78830 (*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*), 1.82 RVU for CPT code 78831 (*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), 2.12 RVU for CPT code 78832 (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), and 0.47 RVU for CPT code 78835 (Radiopharmaceutical quantification measurement(s) single area).

In the proposed rule, CMS also made refinements to the RUC-approved practice expense inputs. CMS proposed to refine the minutes for “Prepare, set-up and start IV, initial positioning and monitoring of patient” to the standard 2 minutes for CPT codes 78800, 78801, 78802, 78803, 78804, 78831, and 78832, which also impacts the equipment time calculations. For CPT codes 78800, 78801, 78802, 78803, 78804, 78831, and 78832, CMS proposed to refine the equipment times to match the standard calculation for the professional PACS workstation. CMS also proposed to refine supply item “sanitizing cloth-wipe (surface, instruments, equipment)” to a quantity of 5 for CPT codes 78801, 78804, and 78832 to conform with the other codes in the family.

In the final rule, CMS addressed commenters’ concern about the validity of Harvard times and their use in code valuation, stating that the validity of existing times should be assumed and is critical in the relativity value system. CMS also maintains that applying a time ratio and the use of increments and percentages are appropriate methodologies for valuation. **CMS finalized 0.64 RVU for CPT code 78800, 0.73 RVU for CPT code 78801, 0.80 RVU for CPT code 78802, 1.09 RVU for CPT code 78803, 1.01 RVU for CPT code 78804, 1.49 RVU for CPT code 78830, 1.82 RVU for CPT code 78831, 2.12 RVU for CPT code 78832, and 0.47 RVU for CPT code 78835.**

In the final rule, CMS acknowledged that commenters clarified that the additional minutes requested for “prepare, set-up and start IV...” was necessary for setting up the patient in camera as well as handling the radiotracers. Commenters also clarified that 10 wipes are necessary for procedures requiring two radiotracers, while only 5 wipes are necessary for procedures with one radiotracer. **CMS finalized the RUC-recommended time for preparing the room and setting up the patient, and also accepted the RUC-recommended quantities for the wipes.**

Invoices were also submitted to CMS, along with a request to update the price for the “gamma camera system, single-dual head SPECT CT” equipment item. The commenter felt that the current price listed by CMS undervalued the equipment and, therefore, the services. **CMS updated the pricing of the “gamma camera system”, effective CY 2020, based on the submission of five invoices.**

Myocardial PET (CPT Codes 78459, 78429, 78491, 78430, 78492, 78431, 78432, 78433, and 78434) (Page 696)

CPT code 78492 (*Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); multiple studies at rest and stress (exercise or pharmacologic)*) was identified on the High Volume Growth Screen with Medicare utilization over 10,000 that increased by at least 100 percent from 2009 through 2014. The CPT Editorial Panel restructured the code family by deleting a Category III code, adding six new codes, and revising three existing codes in order to separately identify component services included for myocardial imaging using positron emission tomography.

In the proposed rule, CMS disagreed with the RUC-recommended value for all nine codes in the family CMS applied a time-to-value ratio calculation to propose a value of 1.00 RVU for CPT code 78491 (*Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); single study, at rest or stress (exercise or pharmacologic)*). An incremental approach or a ratio-based calculation was applied to value the other codes in the family: 1.11 RVU for CPT code 78430 (*Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); single study, at rest or stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan*), 1.05 RVU for CPT code 78459 (*Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed) single study*), 1.20 RVU for CPT code 78429 (*Myocardial imaging, positron emission tomography (PET), metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed) single study; with concurrently acquired computed tomography transmission scan*), 1.24 for CPT code 78492 (*Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); multiple studies at rest and stress (exercise or pharmacologic)*), 1.34 RVU for CPT code 78431 (*Myocardial imaging, positron emission tomography, perfusion study (including ventricular wall motion(s), and/or ejection fractions(s), when performed); multiple studies at rest and stress (exercise or pharmacologic), with concurrently acquired computed tomography transmission scan*), 1.51 RVU for CPT code 78432 (*Myocardial imaging, positron emission tomography, combined perfusion with metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed), dual radiotracer (eg, myocardial viability)*), 1.70 RVU for CPT code 78433 (*Myocardial imaging, positron emission tomography, combined perfusion with metabolic evaluation study (including ventricular wall motion(s), and/or ejection fraction(s), when performed), dual radiotracer (eg, myocardial viability); with concurrently acquired computed tomography transmission scan*), and 0.42 RVU for CPT code 78434 (*Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography, rest and pharmacologic stress (List separately in addition to code for primary procedure)*).

In the proposed rule, CMS made refinements to the RUC-approved practice expense inputs. CMS proposed to refine the equipment times to established policies for non-highly, as well as highly technical equipment. Additionally, CMS proposed to refine the equipment times to match the standard calculation for the professional PACS workstation. CMS proposed to assume a 90 percent equipment utilization rate for new equipment items “PET Refurbished Imaging Cardiac Configuration” and “PET/CT Imaging Camera Cardiac Configuration.” CMS also proposed to refine supply item “sanitizing cloth-wipe (surface, instruments, equipment)” to a quantity of 5 for CPT codes 78432 and 78433 to conform with the other codes in the family. CMS proposed not to price new equipment item “Software and hardware package for Absolute Quantitation” since the submitted invoices include a service contract and a software bundle without a clear breakdown of the pricing.

In the final rule, CMS addressed commenters’ concern about the application of time ratios and increments to value procedure codes. CMS maintains that both are appropriate methodologies for valuation. Comments further stated that the proposed valuations do not consider that the physician work involved in these services have changed and that there have been substantial changes in instrumentation, hardware, and software since these codes were created. **CMS refined their proposed values and finalized the RUC-recommended values for this family of codes: 1.61 for CPT code 78459, 1.76 RVU for CPT code 78429, 1.56 RVU for CPT code 78491, 1.67 RVU for CPT code 78430, 1.80 for CPT code 78492, 1.90 RVU for CPT code 78431, 2.07 RVU for CPT code 78432, 2.26 RVU for CPT code 78433, and 0.63 RVU for CPT code 78434.**

In the final rule, CMS acknowledged commenters' concern that moving from contractor pricing to active pricing for the practice expense inputs will drastically impact the payment rates, an estimated reduction of 80%, leading to reduced access to myocardial PET. Commenters requested that CMS maintain the current payment level while they work with physicians, industry, and cardiologist representatives to improve the accuracy of the inputs. **CMS has agreed to delay the adoption of active pricing of these codes until more accurate inputs are developed.** Commenters clarified that 10 wipes are necessary for procedures requiring two radiotracers, while only 5 wipes are necessary for procedures with one radiotracer. **CMS finalized the RUC-recommended quantities for the wipes.**

Several invoices were submitted to CMS for the following items: the "PET Refurbished Imaging Cardiac Configuration", the "PET/CT Imaging Camera Cardiac Configuration", the "Software and Hardware Package for Absolute Quantitation", and the "PET Infusion Cart" (renamed from "PET Generator Infusion Cart"). A new equipment item was created named the "PET Generator (Rubidium)" to cover the cost of the generator, and will be applied to CPT codes 78430, 78431, 78432, 78433, 78434, 78491, and 78492. The invoice for this item was previously erroneously applied to the "PET Generator Infusion Cart." **CMS finalized the pricing for these equipment items.**

Commenters also disagreed with CMS's proposal to assume a 90 percent equipment utilization rate would be typical for the "PET Refurbishing Imaging Cardiac Configuration" and the "PET/CT Imaging Camera Cardiac Configuration" equipment items, providing additional information demonstrating that a 50 percent utilization would be more accurate. **CMS agreed with the commenters and finalized a default 50 percent utilization rate assumption for these equipment items.**

Commenters had concerns about the transition from contractor pricing to relative values at a significantly lower rate than the current rates. They requested that CMS phase in the changes in payment so as not to disrupt services or jeopardize patient access to care. CMS clarified that they considered these codes a family of "revised codes" given their transition from contractor pricing to active pricing status, which would allow any price adjustments to be phased in over two years. **While CMS finalized the RUC-recommended values, they maintained contractor pricing for the TC of these services.**

Geographic Practice Cost Indices (GPCIs) (Page 138)

CMS is required to review and adjust the geographic practice cost indices (GPCIs) at least every 3 years and adjust as necessary. CMS has completed their review and finalized new GPCIs for CY 2020.

Work GPCIs

Work GPCIs reflect the relative costs of physician labor by Medicare fee schedule locality. CMS finalized its proposal to use BLS Occupational Employment Statistics (OES) data (2014 through 2017) as a replacement for the 2011 through 2014 data to calculate the work GPCIs.

PE GPCIs

PE GPCIs measure the relative cost difference in the mix of goods and services comprising practice expense among the fee schedule localities as compared to the national average of these costs. CMS finalized its proposal to use BLS OES used for work GPCIs for purposes of calculating the employee wage component and purchased service index component of the PE GPCI. For the office rent index

component, CMS used the most up to date available, 2013 through 2017, American Community Survey (ACS) 5-year estimates as a replacement for the 2009 through 2013 ACS data.

Malpractice (MP) GPCIs

MP GPCIs measure the relative cost differences among PFS localities for the purchase of professional liability insurance (PLI). The CY 2020 MP GPCI update reflects premium data presumed in effect as of December 31, 2017.

CMS identified 2 technical refinements to the GPCI methodology that yield improvements over the current method. 1) CMS finalized its proposal to weight by total employment when computing county median wages for each occupation code as occupation wage can vary by industry within a county and 2) CMS finalized its proposal to use a weighted average to calculate the final county-level wage index-removes the possibility that a county index would imply a wage of 0 for any occupation group not present in the county's data.

In response to comments regarding the GPCI for Hawaii, CMS encouraged the commenter to submit specific data to illustrate the increased practice costs in the state for future consideration.

Determination of Malpractice Relative Value Units (RVUs) (Page 106)

For 2020, CMS conducted the statutorily required 3-year review of the GPCIs, which coincides with the statutorily required 5-year review of the MP RVUs. The MP premium data used to update the MP GPCIs are the same data used to determine the specialty-level risk factors, which are used in the calculation of MP RVUs. CMS believes it would be logical and efficient to align the update of MP premium data used to determine the MP RVUs with the update of the MP GPCI. CMS finalized its proposal to align the update of MP premium data with the update to the MP GPCIs. In other words, review and if necessary update the MP RVUs at least every 3 years. In aligning the MP RVUs and GPCI updates, CMS will conduct the next statutorily-mandated review and update of both the GPCI and MP RVU for implementation in CY 2023.

CMS proposed to implement the fourth comprehensive review and update of the malpractice RVUs for CY 2020 and sought comments on the proposals.

For the 2020 update, CMS proposed the following methodological improvements to the development of MP premium data and sought comment on these proposed improvements.

1. Downloading and using a broader set of filings from the largest market share insurers in each state, beyond those listed as “physician” and “surgeon” to obtain a more comprehensive data set.
2. Combining minor surgery and major surgery premiums to create the surgery service risk group, which yields a more representative surgical risk factor. In the previous update, only premiums for major surgery were used in developing the surgical risk factor.
3. Utilizing partial and total imputation to develop a more comprehensive data set when CMS specialty names are not distinctly identified in the insurer filings.

For technical component (TC) only services, CMS proposed to assign a risk factor of 1.00, which corresponds to the lowest physician-level risk factor. This is the approach that CMS used in the 2015 update. CMS sought information on the most comparable and appropriate proxy for the broader set of TC-only services that would support assignment of an alternative risk factor.

CMS continues to use service level overrides to determine the specialty for low volume (codes that have 100 allowed services or fewer) services for both PE and MP calculation as finalized in the 2018 MPFS final rule.

In consideration of concerns from commenters, CMS did not finalize the proposed methodological refinement to combine major surgery and minor surgery premiums when both are delineated on the rate filings for a specialty nor are did they finalize the proposal to use a physician work RVU greater than 5.00 as a threshold to categorize surgical services as major surgery (or to categorize surgical services under 5.00 as minor surgery), for the purpose of the analysis. Instead CMS is maintaining the current methodology and only using major surgery premium data when both minor surgery and major surgery are delineated in the rate filings for a specialty (minor surgery premium data are discarded in those cases) and using minor surgery premium data when only minor surgery premium data are delineated in the rate filings for a specialty--to develop surgical risk factors. However, CMS notes that the objective of the proposal was to develop a more representative surgical risk factor by refining the current methodology to allow for the use of rate filings data that delineated minor and major surgery. CMS' work to establish methods to categorize surgical services as minor and major surgery is ongoing. CMS finalized the remainder of the proposals.

Advisory Opinions on the Application of the Physician Self-Referral Law (Page 1194)

CMS proposed amendments to Physician Self-Referral Law advisory opinion regulations. In 2018, there was a request for information on the Physician Self-Referral Law. CMS received comments concerned about certain aspects of the CMS Advisory opinion process for guidance on whether certain referrals would violate that law. CMS sought comments as it relates to

1) Matters subject to advisory opinions, 2) Timeline for issuing advisory opinions, 3) Certification requirement, 4) Fees for the cost of advisory opinions, 5) Reliance on an advisory opinions, and 6) Rescission.

Commenters overwhelmingly supported the proposed modifications to the advisory opinion regulations, and many stated that the modifications, if finalized, would facilitate better understanding of how to comply with the law and help parties to nonabusive arrangements avoid the strict penalties that result from noncompliance.

Based on comments received, CMS reviewed the regulation's current terminology of a request "present[ing] a general question of interpretation" or "pos[ing] a hypothetical situation," and acknowledged that these terms may lack sufficient clarity. Based on the comments received, there appears to be some confusion over how CMS distinguishes a planned arrangement – that is, a specific arrangement that does not yet exist but the requestor in good faith plans to enter – from a hypothetical fact pattern or question of general interpretation. Therefore, CMS removed this terminology at 11.370(b)(1).

CMS finalized its proposed changes to § 411.370(b), with the modifications as described above. In response to commenters' desire for greater clarity around the types of requests that CMS will reject, CMS also added a new paragraph § 411.370(e)(1)(v) to clarify that CMS would decline to accept an advisory opinion request that involves a course of conduct that is not legally permissible for reasons other than section 1877 of the Act.

CMS finalized its proposal to issue advisory opinions within 60 working days of the submission being formally accepted. CMS also finalized a 30-working day expedited review pathway for requests that

only seek a determination that an arrangement is indistinguishable in all material respects to an arrangement that is the subject of a favorable advisory opinion.

Quality Payment Program

MIPS Value Pathways (MVP)

MVP Framework Overview

In the 2020 MPFS proposed rule, CMS introduced the MIPS Value Pathway (MVP) concept as a planned evolution of the MIPS program which they intend to roll out in 2021. The extent of CMS proposals around the MVP was to set forth a definition to apply an MVP framework beginning with the 2021 MIPS performance period. The MVP framework aims to simplify MIPS, improve value, reduce burden, provide more helpful information regarding physician quality to patients, and align the two QPP pathways, MIPS and APMs. The 2020 final rule affirms their intention to continue developing the MVP concept for implementation in 2021.

Based on extensive comments concerning CMS' proposed prescriptive approaches to determining the measures and activities included in MVPs, and the importance of stakeholder engagement in MVP development, CMS revised their language describing input on individual MVPs. Rather than stating (as proposed) that MVPs would comprise of "a subset of measures and activities **specified by CMS**," in the final rule, CMS modified their description by stating that measures and activities in MVPs will be "**established through rulemaking**."

CMS intends to collaborate with stakeholders over the next year to help shape MVPs that account for practice variations, such as specialty, size, and more. CMS explained that MVPs will link quality measure with improvement activities, cost measures, and promoting interoperability measures, acknowledging that there are currently measures and activities in the MIPS program which may meet the criteria for multiple performance categories.

Implementing the MVP

CMS did not determine whether MVP participation will be mandatory or optional in 2021. They emphasized their intention to work closely with clinicians and other stakeholders to provide input and ideas on draft MVP policies and components. Feedback and suggestions will be considered during future rulemaking cycles to help shape the guidelines for MVP participation, including the extent of first year implementation or the feasibility of an initial pilot.

MVP Population Health Quality Measure Set (p. 749)

CMS explained their intention to increasingly utilize administrative claims-based measures in MIPS through MVPs, specifically global- and population-based measures. Many commenters expressed concern with the use of such measures that may not be relevant to particular eligible clinicians' practices. CMS responded by underscoring their plans for ongoing engagement with stakeholders, including clinical experts and professional societies, to form applicable MVPs and foundational population health administrative claims measures that are low burden and meaningful.

CMS accentuated that the population-based quality measures would help them to achieve their goal to ensure the delivery of collaborative, high-quality, and timely care. They explained that by holding all MIPS eligible clinicians accountable for the same population health measures, they may better align

incentives, encourage coordination between clinicians, and promote meaningful progress on measures.

Non-patient facing Clinicians

CMS did not make changes to the previously-established process of reweighting the promoting interoperability and improvement activities categories for non-patient facing clinicians. Clinicians who are considered non-patient facing (as well as groups or virtual groups for whom at least 75% of clinicians are given non-patient facing status) will continue to receive double credit for improvement activities, requiring them to only submit one high-weighted or two medium-weighted IAs to receive full credit. Non-patient facing groups and individuals will also be exempt from the promoting interoperability category, with the 25% PI weight being added to the quality performance category for a total of 70% quality weight.

Facility-based Scoring

Facility-based scoring was implemented in 2019. The measure set for the fiscal year Hospital Value-Based Purchasing (VBP) program that begins during the applicable MIPS performance period would be used for facility-based clinicians. A facility-based group would be defined as one in which 75 percent or more of the MIPS eligible clinicians NPIs billing under the group's TIN are eligible for facility-based measurement as individuals. There are no submission requirements for individual clinicians in facility-based measurement but a group must submit data in the Improvement Activities or Promoting Interoperability performance categories in order to be measured as a group under facility-based measurement. CMS will automatically apply facility-based measurement to MIPS eligible clinicians and groups who are eligible for facility-based measurement and who would benefit by having a higher combined Quality and Cost score. There will be no changes for facility-based scoring eligibility.

Hospital-based MIPS Eligible Clinicians

CMS previously defined a hospital-based clinician as any eligible clinician who furnishes 75% or more of their covered professional services in sites of service designated as inpatient hospital (POS 21), on-campus outpatient hospital (POS 22), off-campus outpatient hospital (POS 19) or an emergency room setting (POS 23). Clinicians designated as hospital-based would be assigned a zero percent weight to the promoting interoperability performance category, with those percentage points being reweighted to another performance category.

For the 2020 performance year, CMS revised the definition of a “hospital-based MIPS eligible clinician” to include groups and virtual groups, provided that more than 75 percent of the NPIs billing under the group's TIN or virtual group's TINs, as applicable, meet the definition of a hospital-based individual MIPS eligible clinician during the MIPS determination period.

Previously, groups or virtual groups needed 100 percent of the NPIs to be hospital-based in order to obtain this special status as a group.

Low Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations

CMS will maintain the low-volume threshold criteria as established in 2019. To be excluded from MIPS in 2020, clinicians or groups would need to meet one of the following three criteria: have \leq \$90K in Part B allowed charges for covered professional services, provide care to \leq 200 beneficiaries, or provide \leq 200 covered professional services under the Physician Fee Schedule. CMS proposes no changes to the opt-in policy established in 2019, which allows physicians who meet some, but not all, of the low-volume threshold criteria to opt-in to participate in MIPS.

CMS is maintaining the small practice bonus of 6 points that is included in the quality performance category score. CMS also proposes to continue awarding small practices 3 points for submitting quality measures that do not meet the data completeness requirements of 70%, while practices that do not meet the small practice designation would receive zero points for measures that fail to meet data completeness.

Small practices may still submit quality data through the Medicare Part B claims submission type for the Quality performance category; however CMS proposed to only allow this option to clinicians or groups who submitted data via claims submission in 2017.

CMS states it will maintain technical assistance to small and rural practices.

MIPS Performance Threshold and Incentive Payments

The Bipartisan Budget Act of 2018 gave CMS the flexibility to set a performance threshold for three additional years (program years 2019-2021) so as to continue an incremental transition to the statutorily required performance threshold based on the mean or median of final scores from a prior period. For the 2019 MIPS performance year, CMS set the MIPS performance threshold at 30 points, and is increasing it to **45 points for the 2020 MIPS performance year and 60 points for the 2021 MIPS performance year**. Additionally, **CMS will increase the exceptional performance bonus threshold to 85 points for the 2020 and 2021 MIPS performance years. CMS is also moving forward with increasing the minimum MIPS penalties and maximum MIPS base incentives from -7%/+7% in 2019 to +9%/-9% for 2020.**

After the 2021 performance year, CMS will begin using the mean and/or median MIPS performance score from previous years to establish the performance threshold. **For the 2022 performance year, CMS estimates that it will use the mean score of 74.01 from performance year 2017 as the performance threshold, however they may consider revising this score after analyzing performance data from 2019 and 2020.** The 2017 score of 74.01 represents the lowest mean of all MIPS performance years thus far, therefore CMS considers this a conservative figure.

MIPS Category Weighting

Contrary to their earlier proposal to lower the weight of the quality category and adjust the cost category upward, CMS has finalized that they will maintain the same performance category weights as 2019. For performance year 2020, quality will be weighted at 45%, cost as 15%, promoting interoperability at 25% and improvement activities at 15%. If a MIPS eligible clinician is scored on fewer than two performance categories, a final score equal to the performance threshold will be assigned and the MIPS eligible clinician will receive a payment adjustment of 0%.

Performance Categories and Reporting

Quality Category

Although CMS will maintain the quality category's weight at 45% for the 2020 performance year, CMS still intends to lower the weight to 35% in 2021 and finally 30% in 2022. CMS also proposes to establish a guideline for removing Quality measures which do not meet the case minimum and reporting volume required for benchmarking after two consecutive years in the MIPS program.

For 2020, CMS proposes to continue allowing eligible clinicians and groups to submit a single measure

via multiple collection types (e.g. MIPS CQM, eCQM, QCDR measures and Medicare Part B claims measures).

In the 2020 proposed rule, CMS announced its intention to remove MIPS measures #146 and #225, “Inappropriate Use of ‘Probably Benign’ Assessment Category in Mammography Screening” and “Reminder System for Screening Mammography.” This would have drastically reduced the number of mammography measures available in the MIPS program. **Fortunately, CMS has elected to keep these measures for performance year 2020.**

Relevant to some clinicians, CMS has also elected to keep measures #110 and #111, “Preventive Care and Screening: Influenza Immunization” and “Pneumonia Vaccination Status for Older Adults.” These measures had been proposed for removal because they would have been duplicative of a new “Adult Immunization Status” measure. This new measure was not finalized for 2020 however, so the original two measures will remain for the 2020 performance year.

Topped-out Measures

CMS will continue to remove topped-out measures according to the previously established 4-year timetable, in which they will be identified as topped-out, subjected to a 7-point scoring cap, and finally removed from the MIPS program entirely.

In 2019, CMS also finalized the proposal that once a measure reaches extremely topped out status (a measure with a mean performance between the 98th and 100th percentile), CMS would propose the measure for removal during the next cycle. **This policy will also continue during the 2020 performance year.**

Measures Proposed for Removal

The following radiology and radiology-adjacent measures have been finalized for removal beginning in the 2020 MIPS program year:

Measure #46: Medication Reconciliation Post-Discharge - This measure has been removed because CMS considers it duplicative of #130: Documentation of Current Medications in the Medical Record.

Measure #131: Pain Assessment and Follow-Up - This measure has been removed because of the correlation between pain assessment and opioid prescriptions.

Measure #345: Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) - This measure has been removed because CMS considers it duplicative of #344: Rate of CAS for Asymptomatic Patients Without Major Complications (Discharged to Home by Postoperative Day #2).

Measure #361: Optimizing Patient Exposure to Ionizing Radiation: Reporting to a Radiation Dose Index Registry - CMS has removed this measure because they do not consider the quality action to be directly related to patient outcomes.

Measure #362: Optimizing Patient Exposure to Ionizing Radiation: Computed Tomography (CT) Images Available for Patient Follow-Up and Comparison Purposes - CMS has removed this measure for the same rationale as #361.

Additionally, CMS has finalized its earlier proposal to remove MIPS measures that do not meet case minimum and reporting volumes required for benchmarking after being in the program for 2 performance periods. CMS believes that low-reported measures do not offer much value to the quality program and would not be an accurate representation of meaningful measurement.

CMS has also finalized its plan to add another criteria for quality measure removal beginning in 2020: if a quality measure is not available for MIPS quality reporting by all MIPS eligible clinicians. This action would target MIPS measure stewards that refuse to allow third party intermediaries, such as QCDRs and qualified registries, to use those measures for MIPS eligible clinicians.

Quality Scoring

CMS will continue to award 3 points for each quality measure that meets data completeness, meets the case minimum of 20 cases, and can be scored against a benchmark. Measures that do not have a benchmark or meet the case minimum requirement but do meet data completeness will also continue to receive 3 points. CMS will maintain the cap on high priority measure bonus points to 10% of the total quality achievement points (i.e. 6 points). They will also maintain the cap for end-to-end electronic reporting bonus points. CMS will also maintain the current improvement scoring methodology for CY 2020 performance year.

CMS has also finalized their proposal to modify benchmarks in cases where high measure performance could potentially lead to inappropriate treatment. CMS noted two measures in particular: MIPS#1 (Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%)) and MIPS #236 (Controlling High Blood Pressure). **For these measures, CMS will set a flat percentage across all collection types where the top decile is higher than 90% in performance-based methodology.** Any performance rate above 90% would be in the top decile and any performance above 80% would be in the second highest decile, and so on. For the 2020 performance year only these two measures will receive the flat percentage benchmark, but others may receive this same benchmarking in future years.

CMS Data Completeness Requirements

According to an analysis of program year 2017 submission data, individuals, groups, and small practices have submitted quality data with an average completeness of roughly 76%, 85%, and 74% respectively. Based on this data, **CMS has elected to raise the data completeness standard to 70% for quality measure data submission for performance year 2020.** This number defines the minimum subset of patients within a measure denominator that must be reported. CMS believes that it is important to incorporate a higher data completeness requirement in order to gain a more accurate representation of the quality category.

In the 2018 and 2019 MPFS final rules, any measure submitted that did not meet data completeness requirements was given 1 measure achievement point, except for small practices which would receive 3 points. **Starting in 2020, CMS intends to award zero points for measures that do not meet data completeness, but will continue to award 3 points to small practices.**

Improvement Activities

In the 2020 Final Rule, non-patient-facing physicians are still required to earn two medium-weighted improvement activities (IAs) or one high-weighted IA to receive full credit in this category. CMS has finalized a significant change for groups reporting IAs. Previously, groups could report an IA as long

as one member of the group had completed that IA. **For 2020, CMS has raised that requirement to at least 50% of the group within any continuous 90-day period.**

Recognizing the importance of appropriate use criteria (AUC) for diagnostic imaging, CMS will continue to offer high-weighted improvement activity (IA) credit for those referring physicians who are early adopters by participating in clinical decision support for 2020. The seven medium-weighted IAs related to ACR's R-SCAN program will also continue to be available.

For 2020 MIPS performance year CMS has finalized the addition of 2 new improvement activities, the modification of 7 existing improvement activities and the removal of 15. CMS has also finalized a set of criteria to be used in determining whether an IA should be removed for future program years. This criteria closely aligns with the guidelines for removing quality measures, and is finalized as follows:

- Factor 1: Activity is duplicative of another activity;
- Factor 2: There is an alternative activity with a stronger relationship to quality care or improvements in clinical practice;
- Factor 3: Activity does not align with current clinical guidelines or practice;
- Factor 4: Activity does not align with at least one meaningful measures area;
- Factor 5: Activity does not align with the quality, cost, or Promoting Interoperability performance categories;
- Factor 6: There have been no attestations of the activity for 3 consecutive years; or
- Factor 7: Activity is obsolete.

Promoting Interoperability Category

CMS re-established automatic reweighting of the Promoting Interoperability category for “non-patient facing” groups, which was erroneously altered in a previous rulemaking. (p. 1426)

For the 2023 MIPS payment year, CMS established a performance period of a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year (p. 1397).

CMS finalized relatively minor modifications to the objectives, measures, and measure exclusions. The “Query of Prescription Drug Monitoring Program (PDMP)” measure will be optional in 2020, and will be a “yes/no” attestation beginning in 2019 (p. 1403). The e-Prescribing measure will be worth up to 10 points in CY 2020 (p. 1403). The “Verify Opioid Treatment Agreement” measure will be eliminated beginning in CY 2020 (p. 1406). If excluded from the “Support Electronic Referral Loops by Sending Health Information” measure, the 20 points will be redistributed to the “Provide Patients Access to Their Health Information” measure beginning in 2019 (p. 1408). Finally, CMS clarified the prerequisites of the “Support Electronic Referral Loops by Receiving and Incorporating Health Information” measure exclusion (p. 1410).

With these changes, the basic Promoting Interoperability scoring methodology for participants during the 2020 performance period will be as follows (Table 49, p. 1417):

Objectives	Measures	Maximum Points
eRx	eRx	10 pts (exclusion available)
	Query of PDMP	5 pts (bonus)
Health Information Exchange	Support Electronic Referral Loops by Sending Health Information	20 pts (exclusion available)
	Support Electronic Referral Loops by Receiving and Incorporating Health Information	20 pts (exclusion available)
Provider to Patient Exchange	Provide Patients Electronic Access to Their Health Information	40 pts
Public Health and Clinical Data Exchange	Report to two different public health agencies or clinical data registries for any of the following: Immunization Registry Reporting, Electronic Case Reporting, Public Health Registry Reporting, Clinical Data Registry Reporting, and Syndromic Surveillance Reporting	10 pts (exclusions available)

Cost Category

CMS has maintained the 15% category weight for the 2020 performance year and has decided to reconsider raising the category weight for the 2021 performance year. CMS will use the performance feedback from this category to establish weight adjustments for future payment years.

New Cost Measures

CMS has finalized the inclusion of ten new episode-based cost measures for implementation in 2020:

Episode Measure Topic	Measure Type
Non-Emergent Coronary Artery Bypass Graft (CABG)	Procedural
Femoral or Inguinal Hernia Repair	Procedural
Lower Gastrointestinal Hemorrhage	Acute inpatient medical condition
Elective Primary Hip Arthroplasty	Procedural
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural

Hemodialysis Access Creation	Procedural
Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation	Acute inpatient medical condition
Acute Kidney Injury Requiring New Inpatient Dialysis	Procedural
Renal or Ureteral Stone Surgical Treatment	Procedural
Lumpectomy, Partial Mastectomy, and Simple Mastectomy	Procedural

These cost measures were developed by 10 clinical subcommittees convened by a CMS contractor and were successfully reviewed by the National Quality Forum (NQF) Measure Applications Partnership (MAP). These measures are attributed to clinicians who provide a trigger service for procedural episodes or bill inpatient Evaluation and Management claims (E/M) for chronic inpatient episodes. **The Lower Gastrointestinal Hemorrhage measure is only reportable by groups.** More detailed information on the specifications for each cost measure can be found [here](#). These episode-based cost measures will not affect radiologists.

Revised Cost Measures

CMS has finalized new attribution methodology for the Total Per Capita Cost (TPCC) measure to more accurately identify a beneficiary’s primary care relationship. When an E/M service is paired with a general primary care service, a year-long risk window is triggered. **CMS has also divided the risk window that falls within the performance period into 13 four-week blocks called beneficiary months, which would be attributed to the corresponding NPI/TIN.** By evaluating beneficiary cost by month rather than by year, CMS will be able to see any changes in patient health characteristics throughout the performance period and better accounts for any changes in the health status of the beneficiary. **CMS has also added service and specialty category exclusions for clinicians that perform non-primary care services.** These exclusions include diagnostic and interventional radiology, so the TPCC measure will not be attributed to these specialties.

CMS has finalized changes to the Medicare Spending Per Beneficiary measure attribution methodology to distinguish between medical and surgical episodes to better recognize the team-based nature of inpatient care and to ensure attribution to multiple clinicians. Patients will be attributed to any TIN that bills 30% or more of E/M services during an inpatient admission. Any clinician that bills at least one E/M in that TIN will receive the attribution. It is a possibility that this measure could be attributed to interventional radiologists in practices that bill E/M services. **CMS has also finalized a service exclusion list that is considered clinically unrelated to the index admission of the revised MSPB clinician measure,** such as unrelated services that are specific to episodes that are aggregated major diagnostic categories. **The Medicare Spending Per Beneficiary (MSPB) measure has a new name change from MSPB to MSPB Clinician** to distinguish it from measures with similar names currently in use.

Virtual Groups

CMS did not make any changes to the virtual group election process. Solo clinicians and clinicians in groups of 10 or fewer will continue to be able to join together to form a virtual group in order to

receive a group score for the MIPS performance. Virtual groups must apply with CMS during the virtual group election cycle.

CMS has finalized to allow virtual groups to be considered “hospital-based” as long as 75% or more of the group’s clinicians meet the hospital-based MIPS eligible clinician designation. Starting in performance year 2020, improvement activities submitted by groups and virtual groups must be completed by at least 50% of the group’s clinicians over any continuous 90-day period. This is a change from previous years, during which groups could report an improvement activity as long as at least one clinician performed the activity.

Payment Adjustments

CMS estimates that the MIPS negative and positive payment adjustments will be equally distributed, as required by statute, at \$584 million each. Up to an additional \$500 million is also available for the 2022 MIPS payment year for additional positive MIPS payment adjustments for exceptional performance for MIPS eligible clinicians who are exceptional performers based on their final score meeting or exceeding the additional finalized performance threshold of 85 points. CMS found that the mean and median final scores for the 2020 MIPS payment year are higher than their original estimate made in the 2020 proposed rule, therefore leading to the higher performance threshold for the 2020 performance year set in the final rule. Final distribution will change based on the final population of MIPS eligible clinicians for the 2022 MIPS payment year and the distribution of final scores under the program.

Physician Compare

CMS will begin reporting MIPS eligible physicians’ overall MIPS final scores and individual performance category scores on the Physician Compare website, as well as aggregate MIPS data showing the range of overall MIPS performance scores and individual category scores. **CMS will also be adding an indicator to physician’s Physician Compare profiles indicating whether they have been scored using facility-based measurement.**

CMS is still considering whether to establish a “value indicator” for MIPS-eligible physicians whose information is published on the Physician Compare website. This would potentially be a numerical composite of their cost, quality, and patient experience and satisfaction scores, representing the overall value and quality of a physician’s care. CMS will take comments into consideration during future rulemaking cycles.

MIPS APMs

CMS discusses the applicability of its proposed MIPS Value Pathways (MVP) to MIPS Alternative Payment Models (MIPS APMs). APMs as a means to pave the way more readily to qualify for MIPS APMs or APMs. Eventually, all clinicians would either participate in an MVP or a MIPS APM. Because quality measures based on an APM’s measures are not always available for MIPS scoring, **CMS proposes to allow APM Entities and MIPS eligible clinicians participating in APMs the option to report on MIPS quality measures for the MIPS Quality performance category.** CMS would choose the high individual or TIN-level score for each eligible clinician in the MIPS APM to determine the APM average for the entity. This option would not be available for virtual group reporters since the virtual score is far removed from the eligible clinician’s performance for quality measures. **CMS requested comments on this proposal.**

Additionally, CMS proposed a MIPS APM Quality Reporting Credit for APM participants in Other MIPS APMs where quality scoring through the APM is not technically feasible. For these

APM participants, CMS proposed a credit equal to 50 percent of the MIPS Quality performance category weight.

Advanced Alternative Payment Models (APMs)

CMS estimates that between 175,000 and 225,000 eligible clinicians would become qualifying APM participants (QPs) for performance year 2020 and that the aggregate total of the APM incentive payment of 5 percent of Part B allowed charges for QPs would be between approximately \$500 and \$600 million for the 2022 payment year. In payment years 2019 through 2024, QPs receive a lump sum incentive payment annually equal to 5 percent of their prior year's estimated aggregate payments for Part B covered professional services. Beginning in 2026, QPs receive a higher annual fee schedule update (.75) than non-QPs (.25).

For payment years 2019 and 2020, eligible clinicians may become QPs only through participation in Medicare APMs. For payment years 2021 and later, eligible clinicians may become QPs through a combination of participation in Medicare APMs and Other Payer Advanced APMs (which is also referred to as the All-Payer Combination Option). The requirements for these new APMs include the use of CEHRT, reporting quality measures that are comparable to those used in the MIPS quality performance category, and a requirement that participants bear a certain amount of financial risk. The process for determining whether an Other Payer APM will meet these criteria is initiated either by the payer or the eligible clinician.

The generally applicable revenue-based nominal amount standard is set at 8 percent or greater for QP Performance Periods extended out to 2024. This standard applies to models that express risk in terms of revenue. The total expenditure-based nominal amount standard is 3 percent or greater beginning with no specified date for expiration or increase.

Bearing Financial Risk for Monetary Losses Expected Expenditures (Page 1710)

In order to ensure that there are more-than-nominal levels of average or likely risk under an Advanced APM, CMS found it necessary to amend the definition of expected expenditures. **CMS finalized the proposal to amend the definition of expected expenditures to be the beneficiary expenditures for which an APM Entity is responsible under an APM.** For episode payment models, expected expenditures means the episode target price. For purposes of assessing financial risk for Advanced APM determinations, the expected expenditures under the terms of the APM should not exceed the expected Medicare Parts A and B expenditures for a participant in the absence of the APM. If expected expenditures under the APM exceed the Medicare Parts A and B expenditures that an APM Entity would be expected to incur in the absence of the APM, such excess expenditures are not considered when CMS assesses financial risk under the APM for Advanced APM determinations.

Although some commenters were opposed to this proposal due to the concern that the new definition could cause some current Advanced APMs to no longer meet the generally applicable nominal amount standard, CMS responded that all Advanced APMs under CY 2019 that currently satisfy the expected expenditure nominal amount standard will continue to do so.

Qualifying APM Participant (QP) and Partial Determinations Application of Partial QP Status (Page 1716)

CMS currently applies Partial QP status at the NPI level across all TIN/NPI combinations (similar to its policy for QP status). However, CMS proposed that beginning with the 2020 QP performance period to only apply Partial QP status to the TIN/NPI combination(s) through which an individual eligible clinician attains Partial QP status. CMS believed that this would allow for more individual clinicians to receive positive MIPS payment adjustments and may incentivize more clinicians to participate in Advanced APMs. However, after proposing this change, CMS investigated the system requirements to implement it, and determined that they will not be able to modify their current data systems to implement this policy for the 2020 QP Performance period, and therefore **CMS did not finalize their proposed change to only apply Partial QP status to the TIN/NPI combination(s) through which an individual eligible clinician attains Partial QP status.**

QP Performance Period (Page 1721)

The QP Performance Period runs from January 1 through August 31 of the calendar year two years prior to the payment year. An eligible clinician is not a QP or Partial QP for a year if the APM Entity group voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period. Additionally, CMS finalized that an eligible clinician is not a QP or Partial QP for a year if one or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period and the eligible clinician does not individually achieve a Threshold Score that meets or exceeds the QP or Partial QP thresholds based on participation in the remaining nonterminating APM Entities.

However, currently under the terms of some Advanced APMs, APM Entities can terminate their participation in the Advanced APM while bearing no financial risk after the end of the QP Performance Period for the year (August 31). Under current regulations, an APM Entity's termination after that date would not affect the QP or Partial QP status of all eligible clinicians in the APM Entity. CMS believes that allowing those eligible clinicians to retain their QP or Partial QP status without having borne financial risk under the Advanced APM through which they attained QP or Partial QP status is not aligned with the structure and principles of the QPP. CMS states that a critical aspect of Advanced APMs is that participants must bear more than a nominal amount of financial risk under the model. If an APM Entity terminates participation without financial accountability, the APM Entity has not borne more than a nominal amount of financial risk.

Therefore, CMS finalized the proposal to revise regulations to state that, beginning in the 2020 QP Performance Period, an eligible clinician is not a QP or Partial QP for the year if: (1) the APM Entity voluntarily or involuntarily terminates from an Advanced APM before the end of the QP Performance Period; or (2) the APM Entity voluntarily or involuntarily terminates from an Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs.

In addition, CMS finalized the proposal to revise regulations to state that, beginning in the 2020 QP Performance Period, an eligible clinician is not a QP for a year if: (1) one or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM before the end of the QP Performance Period, and the eligible clinician

does not individually achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining non-terminating APM Entities; or (2) one or more of the APM Entities in which the eligible clinician participates voluntarily or involuntarily terminates from the Advanced APM at a date on which the APM Entity would not bear financial risk under the terms of the Advanced APM for the year in which the QP Performance Period occurs, and the eligible clinician does not individually achieve a Threshold Score that meets or exceeds the QP payment amount threshold or QP patient count threshold based on participation in the remaining nonterminating APM Entities. Similar changes were finalized for partial QPs as well.

Marginal Risk and Other Payer Advanced APMs (Page 1752)

Historically, CMS has applied the marginal risk requirement as requiring that a payment arrangement exceed the marginal risk rate of 30 percent at all levels of total losses even as the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures. This policy has necessitated that CMS determine that certain other payer arrangements are not Other Payer Advanced APMs even though they include strong financial risk components and well exceed the 30 percent marginal risk requirement at the most common levels of losses in excess of expected expenditures, and employ marginal risk rates below 30 percent only at much higher levels of losses. CMS believes that these other payer arrangements employ the lower marginal risk rates at higher levels of losses in order to protect participants from potentially catastrophic losses and undue financial burden that might arise because of market factors likely outside their control.

CMS finalized their proposal to use the average marginal risk rate for comparison when the marginal risk rate varies depending on the amount by which actual expenditures exceed expected expenditures, with exceptions for large losses and small losses. CMS amended this in an effort to continue to require significant and meaningful financial risk among Other Payer Advanced APMs. CMS noted that in making this change they are not lowering the standard for the applicable marginal risk rate, but rather allowing for new flexibility as to how it can be met.