Fact sheet

Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2020

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Share

Proposed Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2020

On July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that includes proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2020.

The calendar year (CY) 2020 PFS proposed rule is one of several proposed rules that reflect a broader Administration-wide strategy to create a healthcare system that results in better accessibility, quality, affordability, empowerment, and innovation.

Background on the Physician Fee Schedule

Payment is made under the PFS for services furnished by physicians and other practitioners in all sites of service. These services include, but are not limited to, visits, surgical procedures, diagnostic tests, therapy services, and specified preventive services.

In addition to physicians, payment is made under the PFS to a variety of practitioners and entities, including nurse practitioners, physician

assistants, and physical therapists, as well as radiation therapy centers and independent diagnostic testing facilities.

Payments are based on the relative resources typically used to furnish the service. Relative Value Units (RVUs) are applied to each service for physician work, practice expense, and malpractice. These RVUs become payment rates through the application of a conversion factor. Payment rates are calculated to include an overall payment update specified by statute.

PAYMENT PROVISIONS

CY 2020 PFS Rate setting and Conversion Factor

We are proposing a series of standard technical proposals involving practice expense, including the implementation of the second year of the market-based supply and equipment pricing update, and standard rate setting refinements to update premium data involving malpractice expense and geographic practice cost indices (GPCIs).

With the budget neutrality adjustment to account for changes in RVUs, as required by law, the proposed CY 2020 PFS conversion factor is $36.09, a slight increase above the CY 2019 PFS conversion factor of $36.04.

Medicare Telehealth Services

For CY 2020, we are proposing to add the following codes to the list of telehealth services: HCPCS codes GYYY1, GYYY2, and GYYY3, which describe a bundled episode of care for treatment of opioid use disorders.

Payment for Evaluation and Management (E/M) Services

Consistent with our goals of burden reduction, we are proposing to align our E/M coding with changes laid out by the CPT Editorial Panel for office/outpatient E/M visits. The CPT coding changes retain 5 levels of coding for established patients, reduce the number of levels to 4 for office/outpatient E/M visits for new patients, and revise the code definitions. The CPT changes also revise the times and medical decision making process for all of the codes, and requires performance of history and exam only as medically appropriate. The CPT code changes also allow clinicians to choose the E/M visit level based on either medical decision making or time.

We are proposing to adopt the AMA RUC-recommended values for the office/outpatient E/M visit codes for CY 2021 and the new add-on CPT code for prolonged service time. The AMA RUC-recommended values

would increase payment for office/outpatient E/M visits. The RUC recommendations reflect a robust survey approach by the AMA, including surveying over 50 specialty types demonstrate that office/outpatient E/M visits are generally more complex and require additional resources for most clinicians.

We are also proposing to consolidate the Medicare-specific add-on code for office/outpatient E/M visits for primary care and non-procedural specialty care that we finalized in the CY 2019 PFS final rule for implementation in CY 2021 into a single code describing the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition. We are also seeking more information and feedback from the public about the definition, application, and valuation of this code.

We are not proposing to make AMA RUC-recommended changes to global surgery codes as we are in the process of gathering information on global surgery. We have had three reports prepared by RAND, which we release with the proposed rule. We encourage stakeholders to comment on the reports.

Physician Supervision Requirements for Physician Assistants (PAs)

We are proposing to modify our regulation on physician supervision of PAs to give PAs greater flexibility to practice more broadly in the current health care system in accordance with state law and state scope of practice. 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 furnishing their services.

Review and Verification of Medical Record Documentation

We've received feedback from the clinician community in response to our Patients Over Paperwork initiative request for information (RFI). We've heard from multiple stakeholders that undue burden is created when physicians and other practitioners, including those serving as clinical preceptors for students, must re-document notes entered into the medical record by other members of the medical team.

To reduce burden, we are proposing broad modifications to the documentation policy so that physicians, physician assistants, nurse practitioners, clinical nurse specialists, and certified nurse-midwives could review and verify (sign and date), rather than re-documenting,

notes made in the medical record by other physicians, residents, nurses, students, or other members of the medical team.

Care Management Services

We are proposing to increase payment for Transitional Care Management (TCM), which is a care management service provided to beneficiaries after discharge from an inpatient stay or certain outpatient stays.

We are also proposing a set of Medicare-developed HCPCS G codes for certain Chronic Care Management (CCM) services. CCM is a service for providing care coordination and management services to beneficiaries with multiple chronic conditions over a calendar month service period. We are proposing to replace a number of the CCM codes with Medicare-specific codes to allow clinicians to bill incrementally to reflect additional time and resources required in certain cases and better distinguish complexity of illness as measured by time. We are also proposing to adjust certain billing requirements and elements of the care planning services. These changes would also reduce burden associated with billing the complex CCM codes.

Recognizing that clinicians across all specialties manage the care of beneficiaries with chronic conditions, we are also proposing to create new coding for Principal Care Management (PCM) services, which would pay clinicians for providing care management for patients with a single serious and high risk condition.

Comment Solicitation on Opportunities for Bundled Payments under the PFS

We are seeking comment on opportunities to expand the concept of bundling to improve payment for services under the PFS and more broadly align PFS payment with the broader CMS goal of improving accountability and increasing efficiency in paying for the health care of Medicare beneficiaries. We believe that the statute, while requiring CMS to pay for services on the basis of the resources required to furnish the service, allows considerable flexibility for improving the efficiency of health service delivery within the PFS.

Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs)

Section 2005 of the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act established a new Medicare Part B benefit for opioid use disorder (OUD) treatment services, including medications for

medication-assisted treatment (MAT), furnished by opioid treatment programs (OTPs). To meet this statutory requirement, CMS is specifically proposing:

- Definitions of OTP and OUD treatment services;
- Enrollment policies for OTPs;
- Methodology and estimated bundled payment rates for OTPs that vary by the medication used to treat OUD and service intensity, and by full and partial weeks;
- Adjustments to the bundled payments rates for geography and annual updates;
- Flexibility to deliver the counseling and therapy services described in the bundled payments via two-way interactive audio-video communication technology as clinically appropriate; and
- Zero beneficiary copayment for a time limited duration.

CMS intends to implement this benefit beginning January 1, 2020, as required by the SUPPORT Act.

Bundled Payments under the PFS for Substance Use Disorders

In the CY 2019 PFS proposed rule, CMS sought comment on creating a bundled episode of care for management and counseling treatment for substance use disorders. In response to comments received, CMS is proposing to create new coding and payment for a bundled episode of care for management and counseling for OUD. The new proposed codes describe a monthly bundle of services for the treatment of OUD that includes overall management, care coordination, individual and group psychotherapy, and substance use counseling. One code describes the initial month of treatment, which would include administering assessments and developing a treatment plan; another code describes subsequent months of treatment; and an add-on code describes additional counseling. CMS is proposing that the individual psychotherapy, group psychotherapy, and substance use counseling included in these codes could be furnished as Medicare telehealth services using communication technology as clinically appropriate. CMS is also seeking comment on bundles describing services for other SUDs and on the use of MAT in the emergency department setting, including initiation of MAT and the potential for either referral or follow-up care, as well as the potential for administration of long-acting MAT agents in this setting, to help inform whether we should consider proposing to make separate payment for such services in future rulemaking.

Therapy Services

In the CY 2019 PFS final rule, in accordance with amendments to the Medicare law, we established modifiers to identify therapy services that are furnished in whole or in part by physical therapy (PT) and occupational therapy (OT) assistants, and set a de minimis 10 percent standard for when these modifiers will apply to specific services. We also established that the statutory reduced payment rate for therapy assistant services, effective beginning for services furnished in CY 2022, does not apply to services furnished by critical access hospitals because they are not paid for therapy services at PFS rates.

Beginning January 1, 2020, these modifiers are required by statute to be reported on claims. We are proposing a policy to implement the modifiers as required by statute, and apply the 10 percent de minimis standard, while imposing the minimum amount of burden for those who bill for therapy services while meeting the requirements of the statute.

OTHER PROVISIONS

Ambulance Services

CMS is proposing to clarify that there is no CMS-prescribed form for physician certification statements (PCSs) for ambulance transports. So long as the elements required by regulation are clearly conveyed, ambulance suppliers and providers would be free to choose the format by which the information is displayed, and they may find that other forms that may be required by other legal requirements to perform the transport may also satisfy the function of the PCS. CMS is also proposing to grant ambulance suppliers and providers greater flexibility around who may sign a non-physician certification statement in certain circumstances. The proposal would also add licensed practical nurses (LPNs), social workers and case managers as staff members who may sign the non-physician certification statement if the provider/supplier is unable to obtain the attending physician's signature within 48 hours of the transport.

Ground Ambulance Data Collection System

The Bipartisan Budget Act (BBA) of 2018 requires the Secretary to develop a data collection system to collect cost, revenue, utilization, and other information determined appropriate with respect to ground ambulance providers suppliers. In the CY 2020 PFS proposed rule, CMS proposes the data collection format and elements, a sampling methodology that CMS would use to identify ground ambulance organizations for reporting each year through 2024 and not less than

every 3 years after 2024, and reporting timeframes. CMS is also proposing to reduce by 10% the payments that would otherwise be made to a ground ambulance organization that is identified for reporting but fails to sufficiently submit data, as well as a process under which a ground ambulance organization can request a hardship exemption that, if granted by CMS, would allow it to avoid the payment reduction.

Open Payments Program

CMS's Open Payments program promotes a transparent and accountable healthcare system by annually publishing the financial relationships that physicians and teaching hospitals (known as "covered recipients") have with applicable manufacturers and group purchasing organizations (GPOs). The program has been successful in disclosing over 64 million records since August of 2013. CMS continues to reduce the associated burden of reporting under Open Payments while also clarifying and making the data more useful to the public through minor reporting changes to the program. Therefore, CMS is proposing several changes to Open Payments: 1) expanding the definition of "covered recipient;" (as required by the SUPPORT Act) 2); modifying payment categories; and 3) standardizing data on reported medical devices.

Medicare Shared Savings Program

CMS is soliciting comment on how to potentially align the Medicare Shared Savings Program quality performance scoring methodology more closely with the Merit-based Incentive Payment System (MIPS) quality performance scoring methodology. We recognize that accountable care organizations (ACOs) and their participating providers and suppliers dedicate resources to performing well on quality metrics. We believe that aligning quality metrics across programs will reduce burden and will allow ACOs to more effectively target their resources toward improving care. In addition, we propose refining the Shared Savings Program measure set by: 1) removing one measure and adding another to the CMS Web Interface, to maintain alignment with proposals under the Quality Payment Program, and 2) reverting one measure to pay-for-reporting due to a substantive change made by the measure owner.

Stark Advisory Opinion Process

CMS issues written advisory opinions on a case-by-case basis about whether a physician referral for certain health services is prohibited under Section 1877 of the Social Security Act (the "Stark Law"). Last year, CMS issued a Request for Information (RFI) to gather public input

on how to address unnecessary burden created by the physician self-referral law, focusing in part on how it may impede care coordination, a key aspect of value-based healthcare. In response to the RFI, many health systems and provider groups urged CMS to update the regulations governing its advisory opinion process on physician referrals to reduce provider burden and uncertainty around compliance with the Stark Law. Therefore, CMS is soliciting comment on potential changes to its advisory opinion process to address these stakeholder comments. Other comments in response to the RFI are expected to be addressed in separate rulemaking.

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