Medicare Physician Fee Schedule Proposed 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 proposed 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). The ACR will submit detailed comments to Centers for Medicare and Medicaid Services (CMS) by the September 27th comment period deadline. If finalized, the rule changes will be effective Jan. 1, 2020.

Conversion Factor

CMS estimates 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 MPFS proposed changes to radiology of 1 percent decrease, 2 percent decrease for interventional radiology, 1 percent increase for nuclear medicine, and neutral 0 percent change for radiation oncology and radiation therapy centers if the provisions within the proposed rule are finalized.

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

Separate from the proposed rule, on July 26, CMS released AUC claims processing requirements to the Medicare Administrative Contractors (MACs) via Change Request 11268 and to physicians, providers and suppliers billing Medicare MACs via Medicare Learning Network (MLN) Matters article.

The Educational and Operations Testing Period starts January 1, 2020 and CMS expects the ordering professionals (OP) to consult qualified clinical decision support mechanisms (CDSMs) and provide the information to the furnishing providers to report on their claims. During this testing period, claims will not be denied if the furnishing providers fail to include the AUC-related information or does not report the AUC information correctly, however, CMS encourages inclusion.

Payment for Medicare Telehealth Services (Page 108)

For CY 2020, CMS did not receive any requests from the public for additions to the Telehealth list. However, CMS is proposing to add 3 G codes for treatment of opioid use disorders. HCPCS GYYY1, GYYY2, and GYYY3.

Evaluation and Management (E/M) Services (Page 491)

For CY 2021, CMS proposes 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 time for feedback, provider education, and changes to workflow, updates to EHRs and systems.

Office/Outpatient E/M Visit Coding and Documentation
For code 99201-99215, CMS proposes 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 proposes 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)

Office/Outpatient E/M Visit Revaluation (CPT codes 99201-99215)
CMS proposes to adopt the RUC-recommended work RVUs for all of these E/M codes and the new prolonged services add-on code. CMS proposes to establish 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 proposes 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 111). CMS plans to implement changes resulting changes to the E/M services starting January 1, 2021.

Table 27A from the proposed rule: Illustrates the surveyed times for each service period and the surveyed total time. It also shows the actual total time. CMS seeks 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 27B from the proposed rule: 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

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 proposes 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 proposes to delete the extended visit code GPRO1 and adopt the new code, 99xxx. CMS proposes to accept RUC recommended values for this code without refinement.

CMS seeks comments on these proposals and on appropriate valuation for these services.

Comment Solicitation on Opportunities for Bundled Payments under the MPFS (Page 489)
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 is seeking 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.

Physician Supervision Requirements for Physician Assistants (PAs) (Page 207)
CMS received many comments to their CY 2018 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 proposes to revise the regulation that establishes physician supervision requirements for PAs. CMS is proposing 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. CMS proposal mostly defers 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.

Equipment Recommendations for Scope Systems (Page 40)

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 is proposing to establish 23 new scope equipment codes. However, CMS did not receive invoices for many of the new scope equipment items, so they currently do not have a price.

Practice Expense Methodology

Equipment Utilization Rate Assumption (Page 34)

CMS proposes to keep the rate at 50 percent, but welcomes submission of data that would justify an alternative equipment utilization rate.

Equipment Maintenance (Page 35)

The current annual equipment maintenance factor is at 5 percent. CMS does not believe that this is an accurate rate for all equipment. CMS believes 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 proposes to maintain the current annual maintenance factor.

Interest Rates (Page 35)

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

Changes to Direct PE Inputs for Specific Services

Standardization of Clinical Labor Tasks (Page 36)

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.

Updates to Prices for Existing Direct PE Inputs (Page 55)

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 comment period or during other times as part of its annual process.

Market-Based Supply and Equipment Pricing Update (Page 55)

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. The proposed new pricing for the ultrasound room is $410,303.32, increased from $369,945.00. The proposed new pricing for the vascular ultrasound room is $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-notices.html

Potentially Misvalued Services Under the PFS (Page 96)

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. Two of the nominated codes pertain to Radiology. The first publically nominated code is 10005 *(Fine needle aspiration biopsy, including ultrasound guidance; first lesion)*. The non-imaging code in the family, 10021 *(Fine needle aspiration biopsy, without imaging guidance; first lesion)* was also nominated.

The second code, nominated by CMS is 76377 *(3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation))*. CPT code 76377 *(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*)) is being addressed by CMS for CY2020. At the time of survey, the specialties argued that the codes are utilized by different patient populations. However, CMS feels that the codes are similar enough that CPT code 76377 should also be reviewed in order to maintain relativity in the code family.

Proposed Valuation of Specific Codes for CY 2020 (Page 289)

Bone Biopsy Trocar-Needle (CPT codes 20220 and 20225) (Page 297)

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.

CMS disagrees with the RUC-recommended 1.93 RVU for CPT code 20220, and proposes a crosswalk to CPT code 47000 *(Biopsy of liver, needle; percutaneous)* at 1.65 RVU. CPT code 47000 has the same intraservice time, slightly higher total time, and is one of the key reference codes for CPT code 20220. CMS is uncomfortable with the proposed increase in work RVU for CPT code 20220 from 1.27 to 1.93, given the slight decrease in intraservice time (22 minutes to 20 minutes) and only one minute increase in total time (49 minutes to 50 minutes). CMS feels that the change in work time should be reflected in the work RVU. Additionally, CMS believes that the work involved in CPT code 20220 is similar or less than that of CPT code 47000, justifying the crosswalk to 1.93 RVU.

CMS proposes to crosswalk CPT code 20225 to CPT code 30906 *(Control nasal hemorrhage, posterior, with posterior nasal packs and/or cautery, any method; subsequent)*, 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. CMS noted that the RUC-approved times for CPT code 20225 decreased by about 50 percent, while the work recommended work RVU increased by about 60 percent.

CMS proposes to replace the bone biopsy device (SF055) supply with the bone biopsy needle (SC077) for 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 proposes to adopt a 90 percent utilization rate for the CT room (EL007) for CPT code 20225.

Pericardiocentesis and Pericardial Drainage (CPT codes 3X000, 3X001, 3X002, and 3X003) (Page 306)

CPT code 33015 *(Tube pericardiostomy)* was identified as potentially misvalued on a screen of codes with a negative IWPUT 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.

CMS is proposing to refine the values for all four codes in the family. CMS is proposing to crosswalk CPT code 3X000 *(Pericardiocentesis, including imaging guidance, when performed)* to CPT code 43244 *(Esophagogastroduodenoscopy, flexible, transoral; with band ligation of esophageal/gastric varices)* at 4.40 RVU, due to their identical intraservice times and similar total times. CMS also noted that their database search for codes with similar times all had values below the RUC-recommended 5.00 RVU.

CMS is proposing to crosswalk CPT Code 3X001 *(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, due to their identical intraservice times and similar total times. CMS also noted that their database search for codes with similar times all had values below the RUC-recommended 5.50 RVU.

CMS is proposing 5.00 RVU for CPT Code 3X002 *(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)*, which is the survey 25th percentile value. The RUC-recommended 6.00 RVU was based on a crosswalk to CPT code 31603 *(Tracheostomy, emergency procedure; transtracheal)*, due to their identical intraservice times and similar total times. However, CMS believes that the valuation for CPT code 31603 is an outlier, stating that their database search for codes with similar times only yielded one other code (out of 21) that had a value above 5.00 RVU, with the remaining codes having a value below 4.69 RVU.

CMS is proposing 4.29 RVU for CPT code 3X003 *(Pericardial drainage with insertion of indwelling catheter, percutaneous, including CT Guidance)*, which is the survey 25th percentile value. CMS is uncomfortable with the RUC-recommended 5.00 RVU, again due to the increase in work RVU greatly exceeding the increase in survey times compared to the predecessor codes. CMS performed a database search which yielded 45 codes with similar times and RVUs below 5.00. CMS also compared CPT code 3X003 to 3X001 and noted that 3X003 should have a lower RVU based on survey responses. CMS feels that CPT code 31254 supports the 4.29 RVU valuation for CPT code 3X003.

Intravascular Ultrasound (CPT codes 37252 and 37253) (Page 320)

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.

CMS disagrees with the RUC-recommended 1.80 RVU for CPT code 37252 and is proposing to crosswalk 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, which has similar times.

CMS disagrees with the RUC-recommended 1.44 RVU for CPT code 37253 and is proposing 1.19 RVU to maintain the original 0.36 RVU interval between CPT codes 37252 and 37253.

CMS is proposing 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.

Stab Phlebectomy of Varicose Veins (CPT codes 37765 and 37766) (Page 326)

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. CMS agrees with the RUC recommendations.

Lumbar Puncture (CPT codes 62270, 622X0, 62272, and 622X1) (Page 329)

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.

CMS disagrees with the RUC-recommended values for all four codes. For CPT code 62270, CMS is proposing to crosswalk to CPT code 40490 *(Biopsy of lip)* at 1.22 RVU, citing identical intraservice times and similar total times. CMS is uncomfortable with the RUC-recommended 1.44 RVU, which is an increase over the current RVU, given the decrease in total survey time for the procedure.

CMS is proposing 1.73 RVU for CPT code 622X0, based on the 0.51 RVU difference in the RUC-recommended values for CPT codes 62270 and 622X0.

CMS is proposing 1.58 RVU for CPT code 62272, based on the 0.36 RVU difference in the RUC-recommended values for CPT codes 62270 and 62272.

CMS is proposing 2.03 RVU for CPT code 622X1, based on the 0.81 RVU difference in the RUC-recommended values for CPT codes 62272 and 622X1.

X-Ray Exam - Sinuses (CPT codes 70210 and 70220) (Page 350)

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.

For CPT code 70210, the RUC recommended the 25th percentile 0.20 RVU, 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 *(Orthopantogram (eg, panoramic x-ray))*, which have similar times and RVUs. CMS, however, disagrees with the increased valuation and is proposing to maintain the 0.17 RVU, since the total time for 70210 is unchanged and the RUC-recommended 0.20 RVU is at the higher threshold based on their database search of codes with similar times.

CMS agrees with the RUC-recommended 0.22 RVU for CPT code 70220.

X-Ray Exam - Skull (CPT codes 70250 and 70260) (Page 352)

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.

CMS disagrees with the RUC-recommended 0.20 RVU for CPT code 70250, which is already lower than its existing 0.24 RVU. The RUC approved the lower 0.20 RVU due to a decrease in time for the procedure, and is consistent with the survey 25th percentile value. CMS is recommending 0.18 RVU for CPT code 70250, stating that their database search of codes with the same intraservice time yielded a maximum RVU of 0.18 RVU and that 0.20 RVU would be an outlier value.

CMS disagrees with the RUC-recommended 0.29 RVU for CPT code 70260, which is already lower than its existing 0.34 RVU. The RUC approved the lower 0.29 RVU due to a decrease in time for the procedure, and is consistent with the survey 25th percentile value. CMS is recommending 0.28 RVU for CPT code 70260, by applying the 0.10 increment between the current value for 70250 and 70260 (0.24 RVU and 0.34 RVU, respectively) to the CMS-proposed value for 70250 (0.18 RVU).

X-Ray Exam - Neck (CPT code 70360) (Page 354)

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

CMS disagrees with the RUC-recommended 0.20 RVU for CPT code 70360, which is an increase over its existing 0.17 RVU. CMS is uncomfortable with the 0.20 RVU, citing the

unchanged total time for the procedure and insufficient support for the increase in work RVU. CMS is proposing 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.

X-Ray Exam - Spine (CPT codes 72020, 72040, 72050, 72052, 72070, 72072, 72074, 72080, 72100, 72110, 72114, and 72120) (Page 355)

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)*.

CMS agrees 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.

CT-Orbit-Ear-Fossa (CPT codes 70480, 70481, and 70482) (Page 356)

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)*.

CMS disagrees with the RUC-recommended (and current) 1.28 RVU for CPT code 70480 and is proposing 1.13 RVU, consistent with the 12 percent decrease in the surveyed procedure time.

CMS disagrees with the RUC-recommended 1.13 RVU for CPT code 70481 and is proposing 1.06 RVU, consistent with the 23 percent decrease in the surveyed procedure time. The 23 percent decrease is applied to the current 1.38 RVU for CPT code 70481.

CMS accepts the RUC-recommended 1.27 RVU for CPT code 70482.

CT Spine (CPT codes 72125, 72126, 72127, 72128, 72129, 72130, 72131, 72132, and 72133) (Page 358)

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)*, 72132 *(Computed tomography, lumbar spine; with contrast material)*, and 72133 *Computed tomography, lumbar spine; without contrast material, followed by contrast material(s) and further sections)*.

CMS agrees 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.

CMS did not agree with the RUC-recommended 1.07 RVU for CPT code 72125 and is proposing 1.00 RVU, consistent with the other non-contrast codes in the family. The RUC accepted the specialties' recommendation of 1.07 RVU based on the increased intensity and complexity of the cervical spine but CMS states that this was not reflected in the survey times, which is identical to the other non-contrast procedures.

X-Ray Exam - Pelvis (CPT codes 72170 and 72190) (Page 360)

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).*

CMS proposes to accept 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.

X-Ray Exam - Sacrum (CPT codes 72200, 72202, and 72220) (Page 361)

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)*.

CMS disagrees with the RUC-recommended values for all three codes, which were all higher than the existing values. For CPT code 72200, CMS is proposing to maintain the current 0.17 RVU instead of the RUC-recommended 0.20 RVU, citing discomfort with the variability in survey times among the specialties and possible ambiguity with the vignette.

CMS is uncomfortable with the increase in value for CPT code 72202, from the current 0.19 RVU to the 0.26 RVU recommended by the RUC, since there is no change in total procedure time. Taking into consideration the incremental difference between the RUC-recommended values for 72200 and 72202 (0.20 RVU and 0.26 RVU, respectively), CMS is proposing a value of 0.23 RVU (0.17 RVU for 72200 + 0.06 increment) for CPT code 72202.

CMS proposes to maintain the current 0.17 RVU for CPT code 72200 instead of the RUC-recommended 0.20 RVU, citing no change in the total time. CMS further states that the RUC-recommended 0.20 RVU would place it toward the higher end of RVUs for codes with identical times.

X-Ray Exam – Clavicle-Shoulder (CPT codes 73000, 73010, 73020, 73030, and 73050) (Page 364)

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)*.

CMS proposes to accept 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.

CT Lower Extremity (CPT codes 73700, 73701, and 73702) (Page 365)

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)*.

CMS proposes to accept 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.

X-Ray Elbow-Forearm (CPT codes 73070, 73080, and 73090) (Page 365)

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).*

CMS proposes to accept 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.

X-Ray Heel (CPT code 73650) (Page 366)

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.

CMS proposes to accept the RUC-recommended value of 0.16 RVU for CPT code 73650.

X-Ray Toe (CPT code 73660) (Page 366)

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.

CMS proposes to accept the RUC-recommended value of 0.13 RVU for CPT code 73660.

Upper Gastrointestinal Tract Imaging (CPT Codes 74210, 74220, 74230, 74X00, 74240, 74246, and 74X01) (Page 367)

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, 74X00 *(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 74X01 *(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))*.

CMS proposes to accept 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 74X00, 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 74X01.

CMS is proposing refinements to the RUC-approved practice expense inputs. CMS is requesting feedback to support the recommended minutes allotted to the "Perform procedure/service –NOT directly related to physician work" for CPT codes 74210, 74220, 74X00, 74230, 74240, and 74246. CMS is also proposing 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 also impacts the equipment time calculations.

Lower Gastrointestinal Tract Imaging (CPT Codes 74250, 74251, 74270, and 74280) (Page 368)

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).*

CMS proposes to accept 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.

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

Urography (CPT Code 74425) (Page 369)

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.

A change in the patient population yielded increased procedure time, and a higher RUC-recommended value of 0.51 RVU. CMS is proposing to accept the RUC-recommendation.

Abdominal Aortography (CPT Codes 75625 and 75630) (Page 370)

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.

CMS disagrees 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),* which has more time with the same RVU. CMS performed time ratio calculations between CPT code 75625 and 75710 to determine an RVU range they felt was appropriate. From there, CMS identified CPT code 38222 *(Diagnostic bone marrow; biopsy(ies) and aspiration(s))* as a comparator code to use as a crosswalk, resulting in a 1.44 RVU.

CMS proposes to accept the RUC-recommended 2.00 RVU for CPT code 75630.

Angiography (CPT Codes 75726 and 75774) (Page 371)

CPT codes 75726 *(Angiography, visceral, selective or supraselective (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.

CMS is proposing to accept the RUC-recommended value for both codes: 2.05 for CPT code 75726 and 1.01 RVU for CPT code 75774.

X-Ray Specimen (CPT Code 76098) (Page 372)

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. CMS is requesting 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 PE.

CMS is proposing to accept the RUC-recommended 0.31 RVU for CPT code 76098.

3D Rendering (CPT Codes 76376) (Page 373)

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.

CMS is proposing to accept the RUC-recommended 0.20 RVU for CPT code 76376.

Ultrasound Exam – Chest (CPT Code 76604) (Page 373)

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.

CMS is proposing to accept the RUC-recommended 0.59 RVU for CPT code 76604.

X-Ray Exam - Bone (CPT Codes 77073, 77074, 77075, 77076, and 77077) (Page 373)

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)*.

CMS is proposing to accept 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.

SPECT-CT Procedures (CPT Codes 78800, 78801, 78802, 78803, 78804, 788X0, 788X1, 788X2, and 788X3) (Page 374)

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.

CMS disagrees with the RUC-recommended values for all nine codes in the family. 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)*, the RUC recommended 0.70 RVU. Citing a reduction in physician time, CMS is using a time-to-value ratio calculation to propose 0.64 RVU for CPT code 78800.

CMS disagrees with the RUC-recommended 0.79 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)*, which is the current value, citing a

reduction in the intraservice time. Instead, CMS is proposing 0.73 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78800.

CMS disagrees with the RUC-recommended 0.86 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),* which is the current value, citing a reduction in time. Instead, CMS is proposing 0.80 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78800.

CMS disagrees with the RUC-recommended 1.20 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),* which is an increase from the existing value and equal to the survey 25th percentile. Citing a decrease in time, CMS is proposing to maintain the current 1.09 RVU for this code.

CMS disagrees with the RUC-recommended 1.07 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),* which is the current value, citing a reduction in time. Instead, CMS is proposing 1.01 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78800.

CMS disagrees with the RUC-recommended 1.60 RVU for CPT code 788X0 *(Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, single area (eg, head, neck, chest or pelvis), single day of imaging),* which is the survey 25th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. Instead, CMS is proposing 1.49 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78803.

CMS disagrees with the RUC-recommended 1.93 RVU for CPT code 788X1 *(Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when performed); tomographic (SPECT), minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day of imaging, or single area of imaging over 2 or more days),* which is the survey 50th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. Instead, CMS is proposing 1.82 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78803.

CMS disagrees with the RUC-recommended 2.23 RVU for CPT code 788X2 *(Radiopharmaceutical localization of tumor, inflammatory process or distribution of radiopharmaceutical agent(s), (includes vascular flow and blood pool imaging when*

performed); tomographic (SPECT) with concurrently acquired computed tomography (CT) transmission scan for anatomical review, localization and determination/detection of pathology, minimum 2 areas (eg, pelvis and knees, abdomen and pelvis), single day of imaging, or single area of imaging over 2 or more days imaging), which is the survey 50th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. Instead, CMS is proposing 2.12 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78803.

CMS disagrees with the RUC-recommended 0.51 RVU for CPT code 788X3 *(Radiopharmaceutical quantification measurement(s) single area),* which is the survey 25th percentile. To maintain relativity within the code family, CMS is proposing 0.47 RVU for this code based on a calculated 7 percent reduction from the RUC-recommended value.

CMS is proposing refinements to the RUC-approved practice expense inputs. CMS is proposing 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, 788X1, and 788X2, which also impacts the equipment time calculations. For CPT codes 78800, 78801, 78802, 78803, 78804, 788X1, and 788X2, CMS is proposing to refine the equipment times to match the standard calculation for the professional PACS workstation. CMS is also proposing to refine supply item "sanitizing cloth-wipe (surface, instruments, equipment)" to a quantity of 5 for CPT codes 78801, 78804, and 788X2 to conform with the other codes in the family.

Myocardial PET (CPT Codes 78459, 78X29, 78491, 78X31, 78492, 78X32, 78X33, 78X34, and 78X35) (Page 381)

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.

CMS disagrees with the RUC-recommended value for all nine codes in the family. 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),* the RUC recommended 1.56 RVU. Citing a reduction in physician time, CMS is using a time-to-value ratio calculation to propose 1.00 RVU for CPT code 78491.

CMS disagrees with the RUC-recommended 1.67 RVU for CPT code 78X31 *(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),* which is the survey 25th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times in this global period. Instead, CMS is proposing 1.11 RVU for

this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491.

CMS disagrees with the RUC-recommended 1.61 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)*, which is the survey 25th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times in this global period. Instead, CMS is proposing 1.05 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491.

CMS disagrees with the RUC-recommended 1.76 RVU for CPT code 78X29 *(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)*, which is the survey 25th percentile. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. CMS is proposing 1.20 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491.

CMS disagrees with the RUC-recommended 1.80 RVU 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))*, due to the decrease in physician time. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. CMS is proposing 1.24 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491.

CMS disagrees with the RUC-recommended 1.90 RVU for CPT code 78X32 *(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)*, which is based on a a crosswalk to CPT code 64617 *(Chemodenervation of muscle(s); larynx, unilateral, percutaneous (eg, for spasmodic dysphonia), includes guidance by needle electromyography, when performed)*. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. CMS is proposing 1.34 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491.

CMS disagrees with the RUC-recommended 2.07 RVU for CPT code 78X33 *(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))*. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. CMS is proposing 1.51 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491.

CMS disagrees with the RUC-recommended 2.26 RVU for CPT code 78X34 *(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)*, which is based on a crosswalk to CPT code 71552 *(Magnetic resonance (eg, proton) imaging, chest (eg, for evaluation of hilar and mediastinal lymphadenopathy); without contrast material(s), followed by contrast material(s) and further sequences)*. CMS believes this will result in overvaluing this procedure compared to other codes with similar times. CMS is proposing 1.70 RVU for this code, based on the RUC-recommended incremental relationship between this code and CPT code 78491.

CMS disagrees with the RUC-recommended 0.63 RVU for CPT code 78X35 *(Absolute quantitation of myocardial blood flow (AQMBF), positron emission tomography, rest and pharmacologic stress (List separately in addition to code for primary procedure)*, which is the survey 25th percentile. CMS believes this will result in overvaluing this procedure compared to other ZZZ global period codes. Citing a 1/3 reduction in value for CPT code 78491, the code that CMS uses as the base for their valuations of other codes in this family, CMS is proposing 0.42 RVU for this code based on a calculated 1/3 percent reduction from the RUC-recommended value of 0.63 RVU.

CMS is proposing refinements to the RUC-approved practice expense inputs. CMS is proposing to refine the equipment times to established policies for non-highly, as well as highly technical equipment. CMS is proposing to refine the equipment times to match the standard calculation for the professional PACS workstation. CMS is proposing to assume a 90 percent equipment utilization rate for the new equipment items "PET Refurbished Imaging Cardiac Configuration" and "PET/CT Imaging Camera Cardiac Configuration." CMS is also proposing to refine supply item "sanitizing cloth-wipe (surface, instruments, equipment)" to a quantity of 5 for CPT codes 78X33 and 78X34 to conform with the other codes in the family. CMS proposes 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.

Geographic Practice Cost Indices (GPCIs) (Page 83)

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 are proposing new GPCIs in this proposed rule.

Work GPCIs

Work GPCIs reflect the relative costs of physician labor by Medicare fee schedule locality. CMS proposes 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 proposes 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). Proposed 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 proposes 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 proposes 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.

Determination of Malpractice Relative Value Unites (RVUs) (Page 65)
For 2020, CMS is conducting 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 proposes to align the update of MP premium data with the update to the MP GPCIs. Another words, review and if necessary update the MP RVUs at least every 3 years. If CMS align the MP RVUs and GPCI updates, they would conduct the next statutorily-mandated review and update of both the GPCI and MP RVU for implementation in CY 2023.

CMS proposes to implement the fourth comprehensive review and update of the malpractice RVUs for CY 2020 and seeking comments on their proposals.

For the 2020 update, CMS proposes the following methodological improvements to the development of MP premium data and CMS seeks 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 proposes 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 seeks 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. The proposed list of codes and expected specialties is on CMS website. CMS seeks comment on the list of expected specialties.

Advisory Opinions on the Application of the Physician Self-Referral Law (Page 694)
CMS proposes 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 is seeking 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.

Quality Payment Program (QPP)
The fourth year increases the MIPS payment adjustments to +/- 9% in payment year 2022. The proposed rule has a 60-day comment period ending on September 27, 2019. These policies become effective on January 1, 2020.

Of note, CMS is proposing to lower the weight of the quality performance category to 40% and raise the cost category to 20% of the overall performance score for performance year 2020. Several quality measures have also been proposed for removal, many of them potentially applicable to radiologists. CMS proposes to raise the performance threshold to 40 points (from 30 in 2019) and raise the exceptional performance bonus threshold to 80. Small practices will still be able to claim the small practice bonus of 6 points to their quality score.

MIPS Value Pathways (MVP) (p. 719)
MVP Framework Overview p. 720
CMS acknowledged concerns from clinicians and stakeholders about the complexity, burden, lack of performance comparability, questionable meaningfulness and lack of patient focused measurement within the MIPS program. CMS states that although they have made efforts to streamline the program, they are now focusing on more substantial changes to improve MIPS. CMS created the MIPS program with broad flexibility for measure selection, data submission, and individual or group participation, believing that it would compensate for the variations in specialties, sizes, and compositions of clinician practices. However, the MIPS program has proven to be more complex and burdensome than CMS intended.

With that in mind, **CMS is proposing the MIPS Value Pathways (MVPs), a conceptual participation framework for future proposals beginning with the 2021 performance year.** CMS' goal with the MVP is to align measures across the "siloed" MIPS categories to make for a more meaningful and relevant assessment of a clinician's practice. The MVP framework would also incorporate a combination of administrative claims-based measures and specialty/condition specific measures while leveraging Promoting Interoperability measures. If implemented, CMS

intends to eventually have all MIPS eligible clinicians participate in either an MVP or a MIPS APM. This effort also intends to assist clinicians to improve their quality infrastructure to support higher value care and remove APM participation barriers.

To see more in depth information on CMS' vision for the future of MIPS and the MVP, please click here.

Implementing the MVP (p. 725)

MVP Definition p. 725

As a first step in MVP implementation, CMS proposes to define a MIPS Value Pathway as a subset of measures and activities specified by CMS. MVPs could include administrative claims-based population health, care coordination, patient-reported (patient reported outcomes, patient experience and satisfaction), and specialty/condition specific measures. MVPs would include a population health quality measure set, and measures and activities addressing all four MIPS performance categories. Each performance category would be scored according to its current methodology. Current MIPS performance measure collection types would continue in the MVPs, as feasible and practical. Details of the measure collection methods would be addressed in next year's rulemaking cycle.

Quality measures would no longer be available for reporting from a single inventory; clinicians would have to choose the MVP is that is more applicable to their practice. Cost measures would also be assigned to a specific MVP and clinicians would have to meet the case minimum in order to be applied to the payment adjustment. Promoting Interoperability measures would be a pivotal part of each MVP as CMS would like to emphasize care coordination and electronic health information exchange.

MVP Selection and Assignment

It is anticipated that clinicians would have at least one MVP and may fall into multiple MVPs. CMS would like to create a methodology to assign the most relevant MVP(s) to a clinician and/or multispecialty group rather than have the clinician and/or group select their own MVP. **CMS is considering assigning MVPs to clinicians and groups beginning with the 2021 MIPS performance year as MVPs become available.** Alternatively, CMS would consider allowing clinicians to choose their own MVP for the 2021 performance year, and would begin assigning MVPs in the 2022 performance year.

MVP Population Health Quality Measure Set (p. 749)

CMS would like to increase use of administrative claims-based measures in MIPS through MVPs, specifically the use of global and population based measures. CMS recognizes previously identified drawbacks to claims measures such as historical applicability to primary care clinicians/less relevance for many specialists, limited to Medicare fee for service patients, exclusion of other payer patients, and require a large sample for reliable results. CMS states it is working on multiple fronts to find the best and most appropriate measures for the MIPS program such as measures from Shared Savings Program, CPC+ model HEDIS hospital or emergency department utilization measures.

Enhanced Information for Patients (p. 756)

CMS believes that it should increase the focus and inclusion of more patient focused measures in its quality programs; the MVPs would be no exception and could serve to accelerate such inclusion. They also see the use of patient reported outcomes as a means to provide more meaningful clinical information to an individual clinician, which would be particularly beneficial in feedback to specific specialties within multispecialty groups.

Implementation Timeline

CMS anticipates a number of MVPs will be proposed for the 2021 MIPS performance period. Throughout the next year CMS may convene public forum listening sessions, webinars, and office hours, or use additional opportunities such as the pre-rulemaking measures process to understand what is important to stakeholders in regards to MVPs.

Requests for Feedback on MVPs

CMS is requesting information from stakeholders to help shape the MVP framework. CMS would like feedback on the structure and focus of the pathways, the criteria that should be used to select measures and activities, the policies that are needed for small and multi-specialty practices, how information is reported to patients, and whether CMS should move towards individual clinician level reporting rather than groups.
CMS requests feedback on many questions around the following areas:

- MVP Approach, Definition, Development, Specification, Assignment, and Examples
    - Reducing burden
    - Organizing around specialties
    - Assignment of specialties to MVP

- Selection of Measures and Activities for MVPs; flexibility of clinician measure selection choice within an MVP

Non-patient facing Clinicians
CMS is not proposing any 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 65% 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 are no proposed changes for facility-based scoring eligibility.

Hospital-based MIPS Eligible Clinicians
CMS has 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 proposes to revise 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. (p. 863)

Low Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations
CMS proposes to 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 ≤ $90K in Part B allowed charges for covered professional services, provide care to ≤ 200 beneficiaries, or provide ≤ 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 is proposing 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 proposing to increase it to 45 points for 2020 MIPS performance year and 60 points for 2021 MIPS performance year**. Additionally, **CMS proposes to increase the exceptional performance bonus threshold to 80 points for the 2020 MIPS performance year and 85 points for the 2021 MIPS performance year. CMS is 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.**

MIPS Category Weighting
CMS has proposed to increase the weight of the cost category under MIPS for 2020 to 20%, lower the quality category weight to 40% and maintain the weights for promoting interoperability and improvement activities categories at 25% and 15% respectively. 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 (p. 762)

In addition to lowering the Quality category's weight to 40% for the 2020 performance year, CMS outlines its plan 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).

Topped-out Measures

In 2019, CMS 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. **CMS is seeking comment on whether they should increase the data completeness threshold for quality measures that are extremely topped out.** Clinicians may choose measures that they do well on in the MIPS program, and because of this, certain measures may appear to be topped out. **CMS also seeks comment on other alternative methods to identify extremely topped out measures.**

Measures Proposed for Removal

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

Measure #46: Medication Reconciliation Post-Discharge - This measure is proposed for removal because CMS considers it duplicative of #130: Documentation of Current Medications in the Medical Record.

Measure #110: Preventive Care and Screening: Influenza Immunization - This measure is proposed for removal because it is duplicative of a new measure titled "Adult Immunization Status" which has been proposed for addition to the MIPS program for 2020.

Measure #111: Pneumonia Vaccination Status for Older Adults - This measure is proposed for removal for the same reason as #110.

Measure #131: Pain Assessment and Follow-Up - This measure is proposed for removal because of the correlation between pain assessment and opioid prescriptions.

Measure #146: Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Mammography Screening - CMS proposes to remove this measure because it is considered standard of care.

Measure #225: Radiology: Reminder System for Screening Mammograms - This measure is proposed for removal because CMS considers this a structure measure and not a patient outcome measure.

Measure #345: Rate of Postoperative Stroke or Death in Asymptomatic Patients Undergoing Carotid Artery Stenting (CAS) - This measure is proposed for removal 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 proposes to remove 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 proposes to remove this measure for the same rationale as #361.

Additionally, CMS proposes 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 also seeks comment on whether they should delay the removal of a quality measure by a year** as several stakeholders have asked for more notice when a quality measure is deemed for removal.

CMS is seeking input on what factors should be considered in delaying the removal of measures. For example, are low reporting rates a result of measure selection bias when a measure is not meaningful to applicable clinicians or other measures are less burdensome to report.

Finally, CMS proposes to add another criteria for quality measure removal: 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 (p. 905)

CMS would like to 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 proposes to maintain the cap on high priority measure bonus points to 10% of the total quality achievement points (i.e. 6 points). They would also maintain the cap for end-to-end electronic reporting bonus points. CMS is also proposing to maintain the current improvement scoring methodology for CY 2020 performance year.

CMS is proposing to modify benchmarks to avoid the potential for inappropriate treatment beginning with the 2020 CY performance period. Specifically, **CMS would like to set a flat percentage for 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. This policy would be similar to the Shared Savings Program, which uses flat percentages to set benchmarks when a measure has high achievement. Two measures that CMS is considering applying the flat percentage benchmark are MIPS#1 (Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%) and MIPS #236 (Controlling High Blood Pressure). **CMS seeks comment on this proposed flat percentage benchmarking and what future measures this benchmarking should apply to.**

CMS Data Completeness Requirements (p. 769)

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 is proposing 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. **CMS requests comments on this proposal**.

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 Proposed 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. Although CMS hasn't proposed to change the basic requirements of the IA category, CMS has proposed to make a significant change to improvement activity (IA) reporting requirements for group reporters. Previously, groups could report an IA as long as one member of the group had completed that IA. **For 2020, CMS is proposing to raise that requirement to at least 50% of the group within the same continuous 90-day period.**

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

For 2020 MIPS performance year CMS is proposing the addition of 2 new improvement activities, the modification of 7 existing improvement activities and the removal of 15. CMS has also proposed a set of criteria to be used in determining whether an IA should be removed for future program years. This criteria would be closely aligned with the guidelines for removing quality measures, and is proposed 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 proposes to re-establish automatic reweighting of the Promoting Interoperability category for "non-patient facing" groups, which was erroneously altered in the previous rulemaking. (p. 865)

For the 2023 MIPS payment year, CMS proposes to establish 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. 837).

CMS proposes relatively minor modifications to the objectives, measures, and measure exclusions. The "Query of Prescription Drug Monitoring Program (PDMP)" measure will be optional in CY 2020, and will be a "yes/no" attestation beginning in CY 2019 (p. 839). The "Verify Opioid Treatment Agreement" measure will be eliminated beginning in CY 2020 (p. 847). If excluded from the "Support Electronic Referral Loops by Sending Health Information" measure, the points will be redistributed to the "Provide Patients Access to Their Health Information" measure beginning in CY 2019 (p. 850). Finally, CMS proposes to clarify the prerequisites of the "Support Electronic Referral Loops by Receiving and Incorporating Health Information" measure exclusion (p. 851).

Additionally, **CMS requests information on the following subtopics of relevance to the future direction of the Promoting Interoperability category**: potential opioid measures (p. 865); NQF and CDC opioid quality measures (p. 867); a metric to improve efficiency of providers within EHRs (872); the "Provider to Patient Exchange" objective (p. 875); integration of patient-generated health data into EHRs using CEHRT (p. 884); and engaging in activities that promote the safety of the EHR (p. 888).

Cost Category (p.787)

CMS is proposing a 20% category weight for 2020 performance year, a 25% category weight for 2021, and a 30% category weight for 2022 and future years. CMS is requesting comments on whether there should be an alternative weight for years 2020 and/or 2021 MIPS performance years. CMS is statutorily obligated to have a 30% cost category weight for the 2022 performance year, but invites comments on whether the proposed increase is considered a significant transition.

Proposed Cost Measures (p. 795)

CMS is proposing to move forward with 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 proposed for group reporting.** More detailed information on the specifications for each cost measure can be found here. These episode-based cost measures will not affect radiologists.

Proposed Cost Measure Revisions (p. 801)

CMS is proposing to change the 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 is proposing to divide 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 is also proposing to add 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 is proposing 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 proposed 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 proposed name change from MSPB to MSPB Clinician** to distinguish it from measures with similar names currently in use. Further details about the proposed changes can be found here.

Virtual Groups

CMS does not propose 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.

No major changes have been proposed for virtual groups participating in MIPS, but CMS has proposed 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.

CMS also proposes that 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 the same 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 proposed performance threshold of 80 points. 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 is proposing to 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 is also proposing to add an indicator to physician's Physician Compare profiles indicating whether they have been scored using facility-based measurement**.

CMS is also seeking comments on 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 (p. 891)
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 requests comments on this proposal.**

Additionally, CMS proposes 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 proposes 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 1028)

CMS currently defines expected expenditures to be the beneficiary expenditures for which an APM Entity is responsible under an APM. For episode payment models, expected expenditures are the episode target price. However, CMS is proposing to amend the definition of expected expenditures, for purposes of assessing financial risk for Medicare and Other Payer Advanced APMs, to be those expected expenditures that do 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. This would prevent the risk adjustments of APMs from misrepresenting its level of expenditures that may minimize the level of reported potential losses.

Qualifying APM Participant (QP) and Partial Determinations
Application of Partial QP Status (Page 1035)

CMS currently applies Partial QP status at the NPI level across all TIN/NPI combinations (similar to its policy for QP status). However, CMS is proposing 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 believes that this may allow for more individual clinicians to receive positive MIPS payment adjustments and may incentivize more clinicians to participate in Advanced APMs.

QP Performance Period (p. 1038)

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 proposes 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 is proposing 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 are proposed for partial QPs as well.

QP and Partial QP Thresholds

Final Qualifying APM Participant (QP) Thresholds and Partial Qualifying APM Participant (Partial QP) Thresholds Note: The percentages included in this table were finalized in the CY 2017 QPP Final Rule for all applicable years, and CMS did not propose or finalize any policies to update these percentages in the CY 2018, CY 2019 or CY 2020 QPP Rules.

Payment Year	Payment Amount Threshold			Patient Threshold		
	Medicare Only Option	All Payer Combination Option		Medicare Only Option	All Payer Combination Option	
		Medicare Payments	All Payer Payments		Medicare Patients	All Payer Patients
QP Thresholds						
2019 and 2020	25%	N/A	N/A	20%	N/A	N/A
2021 and 2022	50%	25%	50%	35%	20%	35%
2023 onward	75%	25%	75%	50%	20%	50%
Partial QP Thresholds						
2019 and 2020	20%	N/A	N/A	10%	N/A	N/A
2021 and 2022	40%	20%	40%	25%	10%	25%
2023 onward	50%	20%	50%	35%	10%	35%

List of Current Advanced Alternative Payment Models Recognized by CMS

- Bundled Payments for Care Improvement (BPCI) Advanced
- Comprehensive ESRD Care (CEC) – Two-Sided Risk
- Comprehensive Primary Care Plus (CPC+)
- Medicare Accountable Care Organization (ACO) Track 1+, 2, 3, Basic Level E, and ENHANCED Track
- Next Generation ACO Model
- Oncology Care Model (OCM) – Two-Sided Risk
- Comprehensive Care for Joint Replacement (CJR) Payment Model (Track 1-CEHRT)
- Vermont Medicare ACO Initiative (as part of the Vermont All-Payer ACO Model)
- Maryland All-Payer Model (Care Redesign Program)
- Maryland Total Cost of Care Model (Maryland Primary Care Program and Care Redesign Program)

For a side-by-side comparison of CY 2019 final rule and CY 2020 proposed rule, please refer to CMS' Fact Sheet.

ACR staff continue to further analyze the proposed rule and will be submitting comments to CMS by the September 27th deadline.