

2020 Medicare Physician Fee Schedule and Quality Payment Program Proposed Rule Summary

The Centers for Medicare & Medicaid Services (CMS) released a proposed rule for the 2020 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP). The proposed rule covers diverse topics including Evaluation/Management (E/M) office visit services and a new participation framework in the Merit-based Incentive Payment System (MIPS). CMS is accepting comments on the provisions in this rule through September 27, 2019.

Medicare Physician Fee Schedule

CY 2020 Conversion Factor

The proposed CY 2020 Medicare Physician Fee Schedule (PFS) conversion factor is \$36.09 (CY 2019 conversion factor was \$36.04). The conversion factor update of +0.14 percent reflects a budget neutrality adjustment for reductions in relative values for individual services in 2020.

Relative Value Unit (RVU) and Geographic Practice Cost Index (GPCI) Updates

Physician Work RVU Updates

CMS has proposed to accept approximately 70% of the RUC recommendations for CY2020. ASE is pleased that CMS accepted the AMA RUC recommendation of 0.24 wRVU and related direct PE inputs for CPT Code 933X0 – Myocardial Strain Imaging. This new category I CPT Code will be published for use in January 1, 2020. **ASE will provide additional details on this code once published by AMA CPT.**

Practice Expense RVU Updates

Updates to the direct practice expense inputs are proposed for individual codes based on recommendations from the RUC. CMS will continue to transition to updated pricing for medical supplies and equipment. ASE was able to mitigate additional cuts to several components of the echocardiography practice expense by providing invoices to CMS for supplies and equipment. However, it should be noted that there appears to be an error in calculation of PE for CPT code 93308. **ASE will continue to collect invoices to refute the cuts to and meet with CMS to clarify inputs and calculations for CPT code 93308.**

Professional Liability Insurance (PLI) RVU Updates

CMS is required to update PLI premium data each five years. In 2020, CMS proposes to utilize new premium data and modify elements of the methodology. The impacts of these new data and methodology, range from +1% in payment to Emergency Medicine to -1% in payment to Neurosurgery. Cardiology in general had a zero impact, but as you see in the table below there are slight movements in individual codes due to the PLI changes. The RUC's PLI Workgroup convened in August to consider this proposal and help formulate comments. **Echocardiography services saw a movement of PLI for services performed. ASE will continue to monitor and comment on this issue.**

Below is a chart highlighting CY2020 proposed payment amounts:

CPT code	Description	CY2019 Final Total Non-Facility RVUs	CY2020 Proposed Total Non-Facility RVUs	Variation - CY2019 - CY2020 wRVUS	CY2019 Final Total Non-Facility Payment	CY2020 Proposed Total Non-Facility Payment	Variation - CY2019 - CY2020 Payment
93303	Echo transthoracic	6.65	6.52	-2%	\$ 239.66	\$ 235.31	-2%
93304	Echo transthoracic	4.53	4.50	-1%	\$ 163.26	\$ 162.41	-1%
93306	Tte w/doppler complete	5.84	5.83	0%	\$ 210.47	\$ 210.40	0%
93307	Tte w/o doppler complete	3.97	3.98	0%	\$ 143.08	\$ 143.64	0%
93308	Tte f-up or lmtd	2.78	2.77	0%	\$ 100.19	\$ 99.97	0%
93312	Echo transesophageal	6.97	6.91	-1%	\$ 251.19	\$ 249.38	-1%
93313	Echo transesophageal	0.33	0.32	-3%	\$ 11.89	\$ 11.55	-3%
93314	Echo transesophageal	6.73	6.68	-1%	\$ 242.54	\$ 241.08	-1%
93315	Echo transesophageal	3.66	3.64	-1%	\$ 131.90	\$ 131.37	0%
93316	Echo transesophageal	0.79	0.78	-1%	\$ 28.47	\$ 28.15	-1%
93317	Echo transesophageal	2.64	2.62	-1%	\$ 95.14	\$ 94.56	-1%
93318	Echo transesophageal intraop	2.98	2.95	-1%	\$ 107.40	\$ 106.47	-1%
93320	Doppler echo exam heart	1.51	1.50	-1%	\$ 54.42	\$ 54.14	-1%
93321	Doppler echo exam heart	0.76	0.75	-1%	\$ 27.39	\$ 27.07	-1%
93325	Doppler color flow add-on	0.71	0.69	-3%	\$ 25.59	\$ 24.90	-3%
93350	Stress tte only	5.31	5.34	1%	\$ 191.37	\$ 192.72	1%
93351	Stress tte complete	6.57	6.61	1%	\$ 236.78	\$ 238.55	1%
93352	Admin ecg contrast agent	0.95	0.94	-1%	\$ 34.24	\$ 33.92	-1%
93355	Echo transesophageal (tee)	6.57	6.58	0%	\$ 236.78	\$ 237.47	0%

E/M Office Visit Services

CMS proposes to align its E/M office visit coding changes with the framework adopted by the CPT Editorial Panel. The CPT coding changes will retain 5 levels of coding for established patients, reduce the number of levels to 4 for new patients, and revise the code definitions. A new CPT code for extended office visit time will also be implemented. The changes also revise the times and medical decision-making process for the office visit codes. History and physical exams should continue to be performed as medically appropriate; however, these elements will no longer be a consideration for code level selection. Physicians can choose the E/M visit level based on either medical decision making or time.

CMS is also adopting the AMA RUC recommended values, times, and practice costs for the stand-alone E/M office visits. The RUC recommendations for physician work, time, and direct practice expenses contribute to an approximate 5 percent redistribution between those physicians who routinely provide office visits and those physicians or other health care professionals who do not report office visits.

In addition to the CPT and RUC recommended changes, CMS proposes to implement a Medicare-specific add-on code for E/M office visits describing the complexity associated with visits that serve as a focal point for all medical care or for ongoing care related to a patient's single, serious, or complex chronic condition. CMS impact tables indicate that more than \$1.5 billion will be redistributed between specialties if this code is implemented. **It is anticipated that cardiology will see a 3% increase, however, this will vary by provider and type of services provided.**

The policy changes for the E/M office visits would be effective for services starting January 1, 2021.

Care Management Services

Transitional Care Management (TCM)

CMS examined studies that conclude that patients who receive TCM services have lower hospital readmission rates, lower mortality, and incur lower costs. Based on these findings, CMS seeks to increase the utilization of TCM services and expand payment for care management. To incentivize additional utilization, billing requirements will be modified to allow TCM codes to be reported concurrently with other codes. CMS also proposes to increase payment for the two Transitional Care Management (TCM) codes as recommended by the RUC.

Chronic Care Management (CCM)

CMS is also proposing to adopt new add-on codes for CCM which will allow providers to bill incrementally to reflect additional time resources that are required in certain cases. CMS requests comment on whether to implement G codes for these expanded CCM codes for 2020 or wait for anticipated changes to CPT in 2021. CMS also proposes to clarify the language describing the comprehensive care plan required for CCM codes.

Principal Care Management (PCM)

CMS proposes to create two new codes for PCM services, which would pay physicians for providing care management to patients with a single serious and high-risk condition. The current CCM codes require patients to have two or more chronic conditions. As part of its rationale, CMS cites proposals submitted to the Physician-focused Payment Model Technical Advisory Committee for managing patients with one serious chronic condition. CMS estimates an additional \$125 million in annual spending for these services, offset by reductions to the Medicare conversion factor.

Remote Patient Monitoring (RPM)

CMS will implement a new CPT code to report time spent above and beyond the initial 20 minutes for evaluating patient generated health data obtained through RPM. For all RPM services, CMS proposes to change the current direct supervision requirements to general supervision which allows clinical staff to monitor patient data and interact with patients remotely. CMS also proposes to create six new non-face-to-face codes to describe and reimburse for patient-initiated digital communications that require a clinical decision.

Scope of Practice

Physician Supervision Requirements for Physician Assistants (PAs)

CMS is proposing to change the current policy requiring general physician supervision for PA services to instead provide that the statutory physician supervision requirement for PA services is met when a PA furnishes their services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished. In the absence of state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be evidenced by documentation in the medical record of the PA's approach to working with physicians in furnishing their services.

Medical Record Documentation

CMS proposes to allow physicians, PAs, or Advanced Practice Registered Nurses (APRNs) who document and who are paid under the PFS for their professional services to review and verify (sign and date) rather than re-document notes made in the medical record by other physicians, residents, nurses, students, or other members of the medical team.

Quality Payment Program

MIPS Value Pathways (MVPs)

CMS outlines a new MIPS participation framework that would begin with the 2021 performance year. CMS describes the framework as incorporating a foundation that leverages promoting interoperability measures and a set of administrative claims-based quality measures that focus on population health priorities, which would limit the number of required specialty or condition specific measures physicians are required to report. The MVP framework would also provide enhanced data and feedback to clinicians.

CMS proposes that the MVP framework would include the following:

- Assigning available MVPs to clinicians and groups based on factors such as specialty designation or place of service;
- A base measure set of population health measures which would be included in virtually all the MVPs;
- A unified, smaller set of measures and activities around a clinical condition or specialty;
- Connecting measures and activities from the quality, cost, and improvement activities performance categories;
- Requiring completion of the promoting interoperability performance category;
- Providing timely quality and cost performance data feedback using administrative claims, registry, and electronically submitted data to enhance a clinician self-tracking to facilitate care improvement; and
- Enhancing information available to patients to inform decision making, including increasing patient-reported measures in MVPs.

CMS includes a request for information – Transforming MIPS: MIPS Value Pathways Request for Information – and a diagram and two examples explaining CMS’ view on the future of MIPS. CMS seeks comments on the development and structure of MVP generally. CMS provides a number of specific questions including:

- What should be the structure and focus of the Pathways?
- What criteria should we use to select measures and activities?
- What policies are needed for small and multi-specialty practices?
- Should there be a choice of measures and activities within Pathways?
- How should information be reported to patients?
- Should CMS move toward reporting at the individual clinician level?
- How to select measures for MVP?

ASE is reviewing the RFI and will determine response to CMS’ RFI.

Performance Threshold

CMS proposes to increase the performance threshold from 30 points to 45 points in 2020 and 60 points in 2021. CMS also proposes to increase the exceptional performance threshold from 70 to 80 points in 2020 and to 85 points in 2021. CMS also provides estimates for future performance thresholds, when current law requires that they be set based on mean or median performance in previous years. It estimates that the performance threshold for 2022 will be 74.01 points, which was the mean score in 2017.

Performance Category Weights

CMS proposes to reduce the Quality performance category weight to 40 percent of the final MIPS score in 2020, 35 percent in 2021, and 30 percent in 2022. CMS also proposes to increase the Cost performance category weights by the same percentages – 20 percent in 2020, 25 percent in 2021, and 30 percent in 2022.

Quality Performance Category

- CMS proposes to decrease the quality performance category weight to 40 percent in 2020 performance year.
- CMS is seeking comment on simplifying MIPS by implementing a core measure set using administrative claims-based measures that can be broadly applied to communities or populations and development measure set tracks around specialty areas or public health conditions.
- CMS proposes to increase the data completeness threshold to 70 percent.
- CMS proposes to remove measures that do not meet the case minimum or volumes required for benchmarking for two consecutive years.
- CMS proposes to modify the quality benchmark methodology to some of the outcome and high priority measures due to concern that meeting the benchmark under the existing methodology could result in inappropriate treatment.
- CMS proposes to eliminate 21 percent of the existing quality measures.

Cost Performance Category

- CMS proposes to increase the cost category weight to 20 percent in performance year 2020.
- CMS would add 10 new episode-based measures.
- CMS proposes to revise the current Medicare Spending Per Beneficiary and Total Per Capita Cost measures.

Improvement Activities Performance Category

- CMS proposes to increase the participation threshold from a single clinician to 50 percent of the clinicians in the practice and require that at least 50 percent of a group's providers must perform the same activity for the same continuous 90 days.

If you should have any questions or concerns with the information contained in this overview, please feel free to contact Irene Butler at ibutler@asecho.org.