



AMERICAN ACADEMY OF
ORTHOPAEDIC SURGEONS

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2020 Medicare Physician Fee Schedule Proposed Rule Executive Summary

Payment for Evaluation and Management Services

CMS proposed to assign a separate payment rather than blended payment to each office/outpatient E/M code, except for CPT code 99201 which will be deleted by CPT, as well as the new prolonged visit add-on CPT code (99XXX). CMS also proposed amendments to the policy changes that had been finalized in 2019 for office/outpatient E/M visits, effective January 1, 2021: Separate payment for the five levels of office/outpatient E/M visit CPT codes, as revised by the CPT Editorial Panel effective January 1, 2021 and resurveyed by the AMA RUC, with minor refinement. This would include deletion of Level 1 new patient office/outpatient E/M visit and adoption of the revised CPT code descriptors for CPT codes 99202-99215; elimination of the use of history and/or physical exam to select among code levels; choice of time or medical decision making to decide the level of office/outpatient E/M visit; payment for prolonged office/outpatient E/M visits using the revised CPT code for such services, including separate payment for new CPT code 99XXX and deletion of HCPCS code GPRO1 (extended office/outpatient E/M visit) that was previously finalized for 2021; revise the descriptor for HCPCS code GPC1X and delete HCPCS code GCG0X; and increase in value for HCPCS code GCG1X and allowing it to be reported with all office/outpatient E/M visit levels.

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

CMS proposes adoption of the RVS Update Committee (RUC) recommended work RVUs for all of the office/outpatient E/M codes including the new 15-minute prolonged services add-on code. A public comment was received regarding revaluation of these codes based on a judgment of significant changes in the work.

CMS proposes to remove equipment item ED021 (computer, desktop, with monitor), as it does not believe this item would be allocated to the use of an individual patient for an individual service and is included in overhead costs.

Physician Supervision for Physician Assistant Services

CMS is proposing to modify regulation on physician supervision of physician assistants (PA), giving them greater flexibility to practice more broadly in the current health care system. Physicians must still work in accordance with state law and state scope of practice by documenting in the medical record the PA's approach to working with them and the services they are providing.

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

In response to the comments received on the June 2018 RFI on Stark law, CMS is asking for public comment on how to revise the way it issues advisory opinions, length of time necessary for such review, and related fees.

Proposed Valuation of Specific Codes

27279

CPT code 27279 (*Arthrodesis, sacroiliac joint, percutaneous or minimally invasive [indirect visualization], with image guidance, includes obtaining bone graft when performed, and placement of transfixing device*) was nominated for review as a potentially misvalued service in the 2018 Physician Fee Schedule final rule (82 FR 53017). CMS is proposing to maintain the current work RVU of 9.03 as recommended by the RUC but is also soliciting stakeholder comments on an alternative valuation of code 27280 (*Arthrodesis, open, sacroiliac joint, including obtaining bone graft, including instrumentation, when performed*) which has a work RVU of 20.00. CMS also proposes the RUC-recommended direct practice expense (PE) inputs for CPT code 27279.

97597 and 97598

CPT code 97598 (*Debridement [eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps], open wound, [eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm], including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; each additional 20 sq cm, or part thereof*) was identified by the RUC on a list of services that were originally surveyed by one specialty but are now typically performed by a different specialty.

CPT code 97597 (*Debridement [eg, high pressure waterjet with/without suction, sharp selective debridement with scissors, scalpel and forceps], open wound, [eg, fibrin, devitalized epidermis and/or dermis, exudate, debris, biofilm], including topical application(s), wound assessment, use of a whirlpool, when performed and instruction(s) for ongoing care, per session, total wound(s) surface area; first 20 sq cm or less*) was included for review as part of the family despite being reviewed at the October 2018 RUC meeting.

CMS disagrees with the RUC-recommended work RVU of 0.88 for CPT code 97597 and is proposing a work RVU of 0.77. CMS agrees with the RUC-recommended work RVU of 0.50 for CPT code 97598. CMS also proposes the RUC-recommended direct PE inputs for all codes in the family.

98X00, 98X01, and 98X02

CMS is proposing separate payment for online digital assessments via three HCPCS G-codes that mirror the RUC recommendations for CPT codes 98X00-98X02 for CY 2020. CMS proposes the direct PE inputs associated with CPT codes 98X00, 98X01, and 98X02 for GNPP1, GNPP2, and GNPP3 respectively.

Comment Solicitation on Opportunities for Bundled Payments Under the Physician Fee Schedule

Under the Physician Fee Schedule (PFS), Medicare typically makes a separate payment for each individual service furnished to a beneficiary based on the RVUs. CMS is interested in new options for establishing PFS payment rates or adjustments for services that are furnished together. Hence, CMS is seeking public comments on opportunities to expand the concept of bundling payments under the PFS beyond what is being done at the CMS Innovation Center.

Medicare Enrollment of Opioid Treatment Programs and Enhancements to Existing General Enrollment Policies Related to Improper Prescribing and Patient Harm

CMS currently lacks the legal basis to take administrative action against a physician or other eligible professional for a matter related to patient harm based solely on an independent review organization (IRO) determination or an administrative action imposed by a state oversight board, a federal or state health care program, or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care. CMS believes that its authority to act to stem such behavior should be expanded to include the scenarios identified in proposed § 424.530(a)(15) and § 424.535(a)(22).

Updates to the Quality Payment Program

CMS is proposing a new Merit-Based Incentive Payment System (MIPS) Value Pathway (MVP) beginning with the 2021 MIPS Performance Period/2023 MIPS Payment Year. The MVP proposal seeks to address issues of clarity and meaningfulness by unifying the four existing performance categories (i.e. quality, cost, promoting interoperability, improvement activities) to encompass a “track” of activities that more closely align with actual clinical episodes of care. Its goal is to have some specialty specific and/or health condition specific measures incorporated into such a framework. Since this is a very early-stage concept, CMS is looking for considerable feedback on this proposal.

Promoting Interoperability

CMS is proposing to make the *Query of Prescription Drug Monitoring Program (PDMP)* measure optional in CY 2020, remove the numerator and denominator measure-type and instead require yes/no attestation beginning in CY 2019. The *Query of PDMP* measure will be eligible for five bonus points in CY 2020.

CMS proposes to remove the *Verify Opioid Treatment Agreement* measure beginning in CY 2020.

Physician Compare

CMS proposes to publicly report aggregate MIPS data (including minimum and maximum MIPS performance category and final scores for eligible clinicians) beginning with CY 2018 data, which will be available in CY 2019.