

## **Medicare Physician Fee Schedule Proposed Rule 2020** **Summary**

### ***Payment for Evaluation and Management (E/M) Services***

CMS finalized several coding, payment and documentation changes under the PFS for CPT codes 99201-99215 (office/outpatient E/M visits). These policy changes were finalized with an effective date of January 1, 2021.

In 2019, CMS finalized the following changes for CY 2021:

- Reduction in payment variation for office/outpatient E/M visit levels by paying a single blended rate for E/M visit levels 2 through 4 (one rate for established patients and one for new patients), while maintaining the rate for office/outpatient E/M visit level 5. Practitioners will still report the appropriate code for the level of service furnished, since CMS did not replace these codes with HCPCS G-codes and will continue to use typical times associated with each individual CPT code when time is used to document the office/outpatient E/M visit.
- Permitting practitioners can choose to document office/outpatient E/M level 2 through 5 visits using MDM or time, or the current framework based on the 1995 or 1997 Guidelines.
- Due to the blended payment rate for level 2 through 4 E/M visits, CMS is proposing a minimum supporting documentation standard to support a level 2 office/outpatient E/M visit code for history exam and/or MDM.
- If time is used to document, practitioners will document the medical necessity of the E/M visit and that the practitioner personally spent the required amount of face-to-face time with the patient. The required face-to-face time will be the typical time for the reported code, except for extended or prolonged visits where extended or prolonged times will apply.
- CMS is proposing HCPCS add-on G-codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care (HCPCS codes GPC1X and GCG0X). These codes reflect the differential resource costs associated with performing certain types of office/outpatient E/M visits and are only reportable with office/outpatient E/M level 2 through 4 visits.
- Adoption of a new “extended visit” add-on G-code (HCPCS code GPRO1) for use only with office/outpatient E/M level 2 through 4 visits, to account for the additional resources required when practitioners need to spend extended time with the patient for these visits.
- The existing prolonged E/M codes can continue to be used with level 1 and 5 office/outpatient E/M visits.

### ***Implementation Timeframe***

CMS proposed amendments to the 2019 policy changes 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 CPT code 99201 (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 MDM to decide the level of office/outpatient E/M visit (using the revised CPT interpretive guidelines for medical decision making)
- 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
- Increase in value for HCPCS code GCG1X and allowing it to be reported with all office/outpatient E/M visit levels

CMS proposed to assign separate payment rather than a 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).

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

Since the CPT E/M coding changes will take effect in 2021, the AMA RUC conducted a resurvey and revaluation of the office/outpatient E/M visit codes and provided their recommendations to CMS. CMS proposes adoption of the RUC-recommended work RVUs for all of the office/outpatient E/M codes including the new 15-minute prolonged services add-on code.

The proposed work RVUs are as follows:

- wRVU of 0.93 for CPT code 99202 (*Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter*)
- wRVU of 1.6 for CPT code 99203 (*Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter*)
- wRVU of 2.6 for CPT code 99204 (*Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter*)
- wRVU of 3.5 for CPT code 99205 (*Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal*)
- wRVU of 0.7 for CPT code 99212 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter*)
- wRVU of 1.3 for CPT code 99213 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter*)
- wRVU of 1.92 for CPT code 99214 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter*)

- wRVU of 2.8 for CPT code 99215 (*Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter. (For services 55 minutes or longer, see Prolonged Services 99XXX)*)
- wRVU of 0.61 for CPT code 99XXX (*Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)*)

**The code set is effective beginning in CY 2021 and the proposed values would go into effect with those codes on January 1, 2021.**

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

### ***RAND Reports***

**CMS is giving the public and stakeholders time to study three RAND reports to consider an appropriate approach to revaluing global surgical procedures.**

RAND analyzed data collected from the post-operative visits through this claim based reporting for the first year of reporting, July 1, 2017 – June 30, 2018:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-.html>.

RAND collected data on the level of visits: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-.html>.

RAND report on alternatives for revaluing procedures: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Global-Surgery-Data-Collection-.html>

### ***Potentially Misvalued Services under the PFS***

A public comment was received encouraging revaluation of office/outpatient E/M codes 99201-99215 as the commenter believes the work has changed significantly enough to warrant revaluation. CMS acknowledges the points raised by the commenter and will continue to consider the best way to address the significant changes in practice.

### ***Telehealth Services***

Three new HCPCS codes for office-based treatment of opioid use disorder for CY 2020:

- HCPCS code GYYY1: *Office-based treatment for opioid use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.*
- HCPCS code GYYY2: *Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.*
- HCPCS code GYYY3: *Office-based treatment for opioid use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).*

***Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services***

CMS is proposing to establish rules to govern Medicare coverage of, and payment for, OUD treatment services furnished in Opioid Treatment Programs (OTPs). They propose to establish definitions of OUD treatment services and OTP for purposes of the Medicare Program, and methodology for determining

Medicare payment for such services provided by OTPs. *Note:* Orthopaedic Surgeons do not treat OUD, therefore, it is not relevant to our membership.

### ***Bundled Payments Under the PFS for Substance Use Disorders***

In the CY 2019 PFS proposed rule, CMS solicited comment on creating a bundled episode of care payment for management and counseling treatment for substance use disorders. CMS is proposing to establish bundled payments for overall treatment of OUD, including management, care coordination, psychotherapy, and counseling activities. They are also proposing to create two HCPCS G-codes to describe monthly bundles. *Note:* Orthopaedic Surgeons do not treat OUD, therefore, it is not relevant to our membership.

### ***Physician Supervision for Physician Assistant (PA) Services***

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

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

The HHS Secretary and CMS issue written advisory opinions concerning whether a referral relating to designated health services (other than clinical laboratory services) is prohibited under the physician self-referral law and accompanying rules from HHS and the HHS Office of the Inspector General. 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 they issue advisory opinions. They share the following proposals and questions:

- CMS is not proposing an expansion of the scope of requests at this time; however, they are soliciting comments on whether they should do so in the future.
- CMS is proposing to clarify that the request for an advisory opinion must “relate to” (rather than “involve”) an existing arrangement or one into which the requestor, in good faith, specifically plans to enter. They are also proposing revisions to the regulation text for grammatical purposes.
- CMS is proposing to expand the reasons that CMS will not accept advisory opinion requests.
  - To better focus resources “CMS will reject an advisory opinion request or not issue an advisory opinion with respect to a request that does not describe the arrangement at issue with a level of detail sufficient for CMS to issue an opinion, and the requestor does not timely respond to CMS requests for additional information.”
  - “CMS may elect not to accept an advisory opinion request or issue an advisory opinion if, after consultation with OIG and DOJ, it determines that the course of action described in the request is substantially similar to conduct that is under investigation or is the subject of a proceeding involving HHS or other law enforcement agency.” CMS is seeking comments on this proposal.
- CMS is proposing to modify the advisory opinion issuance time period to 60 days from the current 90-day timeframe. The 60-day period would begin on the date that CMS formally accepts a request for an advisory opinion.
- CMS is seeking comments on whether “the existing certification requirement creates burden for requestors.”
- CMS is proposing to adopt an hourly fee of \$220 for preparation of an advisory opinion. They are seeking comments on setting up an expedited process at a cost of \$440 per hour. CMS is considering a cap on the amount of fees charged for an advisory opinion as well as the amount of the cap. CMS also requests feedback on whether they should eliminate the initial \$250 fee currently in place.
- CMS is proposing “that the Secretary will not pursue sanctions under section 1877(g) of the Act against any individuals or entities that are parties to an arrangement that CMS determines is

indistinguishable in all material aspects from an arrangement that was the subject of the advisory opinion” i.e., requestors who have already received a favorable advisory opinion.

- CMS is proposing “to recognize that individuals and entities may reasonably rely on an advisory opinion as non-binding guidance that illustrates the application of the self-referral law and regulations to specific facts and circumstances.” CMS is also seeking comments on rescission of advisory opinions previously issued by them.

### ***Proposed Valuation of Specific Codes***

#### **11981-11983**

CMS did *not* accept the RUC-recommended values for codes 11981-11983. CMS proposes a work RVU of 1.14 for code 11981 (*Insertion, non-biodegradable drug delivery implants*), referencing code 67500 (*Injection of medication into cavity behind eye*) which is a 23 percent reduction from the current total physician time. CMS proposes a work RVU of 1.34 for code 11982 (*Removal, non-biodegradable drug delivery implant*), referencing code 64486 (*Injections of local anesthetic for pain control and abdominal wall analgesia on one side*) which is a 25 percent reduction, and a work RVU of 1.91 for code 11982 (*Removal with reinsertion, non-biodegradable drug delivery implant*), referencing code 62324 (*Insertion of indwelling catheter and administration of substance into spinal canal of upper or middle back*), which is a reduction of 42 percent from the current work RVU. CMS is not proposing any direct PE refinements to codes 11981-11983.

#### **206X0-206X5**

New add-on CPT codes 206X0 – 206X5 are intended to be typically reported with CPT codes 11981 – 11983, with debridement or arthrotomy procedures. CMS did *not* accept the RUC-recommended work value (1.50) for code 206X0 (*Manual preparation and insertion of drug delivery device(s), deep (eg, subfascial)*) and proposes a work RVU of 1.32, referencing code 64634 (*Destruction of upper or middle spinal facet joint nerves with imaging guidance*). CMS did not accept the RUC-recommended work value (2.50) for code 206X1 (*Manual preparation and insertion of drug delivery device(s), intramedullary*) stating that the reference code 11047 (*Debridement, bone (includes epidermis, dermis, subcutaneous tissue, muscle and/or fascia, if performed); each additional 20 sq cm, or part thereof*) is suitable but that they adjusted the work RVU to 1.70 to account for the 25 minutes of intraservice work time versus the reference code’s 30 minutes. CMS also did not accept the RUC-recommended work RVU (2.60) for code 206X2 (*Manual preparation and insertion of drug delivery device(s), intra-articular*) stating again that reference code 11047 is a suitable guide and proposes a work RVU of 1.80 which is 31 percent lower than the RUC-recommended value. CMS proposes the RUC-recommended RVU for codes 206X3 (*Removal of drug delivery device(s)*), 206X4 (*Removal of drug delivery device(s), intramedullary*) and 206X5 (*Removal of drug delivery device(s), intra-articular*).

#### **22310**

Code 22310 (*Closed treatment of vertebral body fracture(s), without manipulation, requiring and including casting or bracing*) was identified through a screen of services with a negative IWPUT and Medicare utilization greater than 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. CMS disagrees with the RUC-recommended value (3.75) and proposes a work RVU of 3.45 crosswalking to CPT code 21073 (*Manipulation of temporomandibular joint(s) (TMJ), therapeutic, requiring an anesthesia service (ie, general or monitored anesthesia care)*). CMS believes this better accounts for the decrease in the surveyed work time as the crosswalk code has an identical intraservice time and similar total time as those proposed by the RUC for code 22310. CMS is proposing to refine the equipment time for the power table (EF031) to follow their standard for non-highly technical equipment for the direct PE inputs.

#### **26020, 26055, 26160**

These services were identified by the RUC through a screen of services with a negative IWP/UT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. CMS does not agree with the RUC-recommended work RVU of 7.79 based on the survey median stating there is no compelling reason that the service would be significantly more intense to furnish than services with similar times/values. CMS is proposing a work RVU of 6.84 which is the survey 25<sup>th</sup> percentile and falls between the work RVUs of CPT code 28122 (*Partial excision (craterization, saucerization, sequestrectomy, or diaphysectomy) bone (eg, osteomyelitis or bossing); tarsal or metatarsal bone, except talus or calcaneus*) and CPT code 28289 (*Hallux rigidus correction with cheilectomy, debridement and capsular release of the first metatarsophalangeal joint; without implant*).

CMS does not agree with the RUC-recommended increase of work RVU of 3.75 for CPT code 26055 (*Tendon sheath incision (eg, for trigger finger)*) and proposes to maintain the current work RVU of 3.11. CMS is basing this on a total time increment methodology between CPT codes 26020 and 26055. The total time ratio between the recommended time of 119 minutes and the recommended 262 minutes for code 26020 equals 45 percent, and 45 percent of CMS' proposed RVU of 6.84 for CPT code 26020 equals a work RVU of 3.10, which they believe validates the current work RVU of 3.11.

CMS proposes the RUC-recommended work RVU of 3.57 for CPT code 26160 (*Excision of lesion of tendon sheath or joint capsule (eg, cyst, mucous cyst, or ganglion), hand or finger*) noting that their proposed work RVU validates the RUC's contention that code 26160 is slightly more intense to perform than code 26055.

CMS is proposing to refine the quantity of the impervious staff gown supply (SB027) from two to one for CPT codes 26055 and 26160 for direct PE inputs. CMS believes the second staff gown supply is duplicative as this same supply is included in the surgical cleaning pack (SA043). The surgical cleaning pack provides one standalone gown and a second gown that is worn by the practitioner and one assistant.

#### **27220**

CPT code 27220 (*Closed treatment of acetabulum (hip socket) fracture(s); without manipulation*) was identified through a screen of services with a negative IWP/UT and Medicare utilization over 10,000 for all services or over 1,000 for Harvard valued and CMS/Other source codes. CMS disagrees with the RUC-recommended work RVU of 6.00 as they do not believe that the recommendation corresponds with the recommended 19-minute reduction in intraservice time and 80-minute reduction in total time. CMS proposes the 25<sup>th</sup> percentile work RVU of 5.50, crosswalking to CPT code 27267 (*Closed treatment of femoral fracture, proximal end, head; without manipulation*) to account for the decrease in the surveyed work time. Additionally, CMS is proposing to refine the equipment time for the power table (EF031) for direct PE inputs to follow their established standard for non-highly technical equipment.

#### **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 PFS 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. This solicitation is based on a stakeholder request to recognize the payment parity between the two services by crosswalking the work RVU of code 27279 to that of code 27280 (wRVU 20.00). CMS also proposes the RUC-recommended direct PE inputs for CPT code 27279.

#### **72170 and 72190**

CPT code 72190 (*Radiologic examination, pelvis; complete, minimum of 3 views*) was identified as potentially misvalued through a screen of CMS/Other codes with Medicare utilization of 30,000 or more annually. CPT code 72170 (*Radiologic examination, pelvis; 1 or 2 views*) was added as part of the family. CMS accepts the RUC-recommended work RVUs for 72170 (0.17) and 72190 (0.25) as well as the recommended PE inputs.

#### **72200, 72202, 72220**

CPT code 72220 (*Radiologic examination, sacrum and coccyx, minimum of 2 views*) was identified on a screen of CMS/Other source codes with Medicare utilization greater than 100,000 annually. CPT codes 72200 (*Radiologic examination, sacroiliac joints; less than 3 views*) and 72202 (*Radiologic examination, sacroiliac joints; 3 or more views*) were also added as part of the family of codes. CMS is proposing to maintain the current work RVU of 0.17 versus the RUC-recommended RVU of 0.20 for code 72200. CMS does not accept the RUC-recommended work RVU for code 72202 (0.26) and proposes a work RVU of 0.23. CMS states they believe that the increase in RVUs is not warranted due to the unchanged total time required to provide the service and lack of description to account for an increase of intensity relative to the current value. CMS does not accept the RUC-recommended value for CPT code 72200 (0.20) and proposes to maintain the current work RVU of 0.17 noting that there is no change in the total time required to provide the service. CMS is proposing the RUC-recommended direct PE inputs for all codes in the family.

#### **73000, 73010, 73020, 73030, and 73050**

CPT code 73030 (*Radiologic examination, shoulder; complete, minimum of 2 views*) was identified as potentially misvalued through a screen of services with more than 100,000 utilizations annually. 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*) were included for review as part of the same family. CMS is proposing the RUC-recommended work RVUs for all five codes in this family: CPT code 73000 (work RVU 0.16); CPT code 73010 (work RVU 0.17); CPT code 73020 (wRVU 0.15); CPT code 73030 (wRVU 0.18); and CPT code 73050 (wRVU 0.18). CMS proposes the RUC-recommended direct PE inputs for all codes in the family.

#### **73700, 73701, and 73702**

CPT code 73701 (*Computed tomography, lower extremity; with contrast material(s)*) was identified as potentially misvalued on a screen of CMS/Other codes with Medicare utilization of 30,000 or more. Two other lower extremity CPT codes were identified as part of the family, and they were surveyed and reviewed together at the April 2018 RUC meeting. CMS is proposing the RUC-recommended work RVU for all three codes in this family: CPT code 73700 (wRVU 1.00); CPT code 73701 (wRVU 1.16); CPT code 73702 (wRVU 1.22). CMS is proposing the RUC-recommended direct PE inputs for all codes in the family.

#### **73070, 73080, and 73090**

CPT codes 73070 (*Radiologic examination, elbow; 2 views*) and 73090 (*Radiologic examination; forearm, 2 views*) were identified on a screen of CMS/Other source codes with Medicare utilization greater than 100,000 services annually. CPT code 73080 (*Radiologic examination, elbow; complete, minimum of 3 views*) was included for review as part of the same code family. CMS proposes the RUC-recommended work RVU for all three codes in this family as follows: CPT code 73070 (wRVU 0.16); CPT code 73080 (wRVU 0.17); and CPT code 73090 (wRVU 0.16). CMS proposes the RUC-recommended direct PE inputs for all codes in the family.

#### **73650**

CPT code 73650 (*Radiologic examination; calcaneous, minimum of 2 views*) was identified on a screen of CMS/Other source codes with Medicare utilization greater than 100,000 services annually. CMS is proposing the RUC-recommended work RVU of 0.16 as well as RUC-recommended direct PE inputs for CPT code 73650.

### **73660**

CPT code 73660 (*Radiologic examination; toe(s), minimum of 2 views*) was identified on a screen of CMS/Other source codes with Medicare utilization greater than 100,000 services annually. CMS proposes the RUC-recommended work RVU for this code of 0.13 as well as the RUC-recommended direct PE inputs for this code.

### **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 based on a crosswalk to CPT code 27369 (*Injection procedure for contrast knee arthrography or contrast enhanced CT/MRI knee arthrography*). 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. The proposed HCPCS G-codes, their descriptors and work RVUs are as follows:

- HCPCS code GNPP1 (*Qualified nonphysician healthcare professional online assessment, for an established patient, for up to seven days, cumulative time during the 7 days; 5-10 minutes*); RUC-recommended work RVU 0.25 to reflect the work of CPT code 98X00.
- HCPCS code GNPP2 (*Qualified nonphysician healthcare professional online assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 11-20 minutes*); CMS proposes the 25<sup>th</sup> percentile wRVU of 98X01 – 0.44.
- HCPCS code GNPP3 (*Qualified nonphysician qualified healthcare professional assessment service, for an established patient, for up to seven days, cumulative time during the 7 days; 21 or more minutes*). CMS proposes the 25<sup>th</sup> percentile wRVU of 98X02 – 0.69.

CMS proposes the direct PE inputs associated with CPT codes 98X00, 98X01, and 98X02 for GNPP1, GNPP2, and GNPP3 respectively.

AAOS would like to note that we believe there is an error in the MPFS proposed rule. We think CMS inadvertently listed the incorrect code numbers regarding proposed work RVUs for codes GNPP1, GNPP2 and GNPP3. Please see the highlighted text below.

*“For CY 2020, we are proposing a work RVU of 0.25 for CPT code GNPP1, which reflects the RUC-recommended work RVU for CPT code 98X00. For HCPCS codes GNPP2 and GNPP3, we believe that the 25th percentile work RVU associated with CPT codes 98X01 and 98X02 respectively, better reflects the intensity of performing these services, as well as the methodology used to value the other codes in the family, all of which use the 25th percentile work RVU. Therefore, we are proposing a work RVU of 0.44 for HCPCS code GNPP1 and a work RVU of 0.69 for HCPCS code GNPP2.”*

### **99281, 99282, 99283, 99284, and 99285**

CPT Codes 99281-99285 were identified as potentially misvalued. CMS is proposing the RUC-recommended work RVU of 0.48 for CPT code 99281, work RVU of 0.93 for CPT code 99282, work RVU of 1.42 for 99283, work RVU of 2.60 for 99284, and work RVU of 3.80 for CPT code 99285. CMS is not proposing any direct PE inputs for these codes.

### **9X0X1, 9X0X2, and 9X0X3**

The RUC reviewed and made recommendations for CPT code 9X0X1 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes*), CPT code 9X0X2 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes*), and CPT code 9X0X3 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes*) which replace two deleted codes from 2018. CMS proposes the RUC-recommended work RVUs of 0.25 for CPT code 9X0X1, 0.50 for CPT code 9X0X2, and 0.80 for CPT code 9X0X3. CMS is proposing the RUC-recommended direct PE inputs for all codes in the family.

### ***Bundled Payments Under the PFS***

Under the 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***

The provider enrollment process is invaluable in helping to ensure that: (1) all potential providers and suppliers are carefully screened for compliance with all applicable requirements; (2) problematic providers and suppliers are kept out of Medicare; and (3) beneficiaries are protected from unqualified providers and suppliers. OTPs that meet all applicable statutory and regulatory requirements will be eligible to bill and receive payment under the Medicare program for furnishing such services to Medicare beneficiaries. *Note:* Orthopaedic Surgeons do not take part in Opioid Treatment Programs; therefore, it is not relevant to our membership.

### ***Patient Harm***

Patient harm is a large part of this section due to the importance of ensuring patient safety in all provider and supplier settings (not just those involving OTPs). CMS is proposing permissible action to revoke or deny, as applicable, a physician or other eligible professional enrolled if he or she has been subject to prior action from a state oversight board, federal or state health care program, Independent Review Organization (IRO) determination(s), or any other equivalent governmental body or program that oversees, regulates, or administers the provision of health care with underlying facts reflecting improper

physician or other eligible professional conduct that led to patient harm. In determining whether a revocation or denial on this ground is appropriate, CMS would consider the following factors: the nature of the patient harm, the nature of the physicians or other eligible professionals conduct, and the number and type(s) of sanctions of disciplinary actions that have been imposed.

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 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 their general rulemaking authority under section 1102 gives them the ability to establish such legal grounds. *“As alluded to in this proposed rule and in previous rulemaking efforts, we have long been concerned about instances of physician or other eligible professional misconduct, and we believe our authority to take action to stem such behavior should be expanded to include the scenarios identified in proposed § 424.530(a)(15) and § 424.535(a)(22).”*

State oversight boards, such as medical boards and other administrative bodies, have found certain physicians and other eligible professionals to have engaged in professional misconduct and/or negligent or abusive behavior involving patient harm. State oversight of licensed physicians or practitioners is, in short, a function entirely different from federal oversight of Medicare. CMS is seeking feedback about the proposed definition of “state oversight board” and the proposed revocation and denial authorities.

#### ***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. CMS’ stated aim with this new proposal is to “improve value, reduce burden, help patients compare clinician performance, and better inform patient choice in selecting clinicians.” CMS acknowledges feedback from stakeholders that the current MIPS framework lacks clarity and meaningfulness and can be burdensome for many clinicians who participate in the program. The MVP proposal seeks to address these issues 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. Their 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.

Below is a direct example from the proposed rule on what an MVP might look like:

<b>MVP Example</b>	<b>Quality</b>	<b>Cost</b>	<b>Improvement Activities</b>	<b>Promoting Interoperability</b>
Major Surgery	<ul style="list-style-type: none"> <li>Unplanned Reoperation within the 30-Day Postoperative Period (Quality ID: 355) <ul style="list-style-type: none"> <li>Surgical Site Infection (SSI) (Quality ID: 357)</li> <li>Patient-Centered Surgical Risk Assessment and Communication (Quality ID: 358)</li> <li>PLUS: population health administrative claims quality measures</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Medicare Spending Per Beneficiary (MSPB_1) <ul style="list-style-type: none"> <li>Revascularization for Lower Extremity Chronic Critical Limb Ischemia (COST_CCLI_1)</li> <li>Knee arthroplasty (COST_KA_1)</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>Use of patient safety tools (IA_PSPA_8) <ul style="list-style-type: none"> <li>Implementing the use of specialist reports back to referring clinician or group to close referral loop (IA_CC_1)</li> </ul> </li> <li>OR</li> <li>Completion of an Accredited Safety or Quality Improvement Program (IA_PSPA_28)</li> </ul>	<ul style="list-style-type: none"> <li>All measures in Promoting Interoperability</li> </ul>

*Citation:* Centers for Medicare and Medicaid Services, Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations.

### ***MIPS Performance Category Changes***

#### ***Quality***

For the Quality performance category, CMS proposes the following weighting:

- 40% for the 2020 Performance Period/2022 Payment Year
- 35% for the 2021 Performance Period/2023 Payment Year
- 30% for the 2022 Performance Period/2024 Payment Year

CMS proposes data completeness requirements of 70 percent for the 2020 Performance Period/2022 Payment Year (this applies to Medicare Part B Claims measures, QCDR measures, MIPS CQMs, and eCQMs).

CMS proposes to remove any MIPS quality measures that do not meet case minimum and reporting volume benchmarking requirements if they have been in the QPP for two consecutive performance periods.

#### ***Cost***

For the Cost performance category, CMS proposes the following weighting:

- 20% for the 2020 Performance Period/2022 Payment Year
- 25% for the 2021 Performance Period/2023 Payment Year

- 30% for the 2022 Performance Period/2024 Payment Year
- 30% for all subsequent years

CMS proposes to include the attribution methodology for each cost performance category in this rule, and all future rules beginning with the 2020 Performance Period.

CMS proposes to give different attribution considerations to those reporting as individuals vs. groups based on measure specifications; this is different than the current process that attributes both individuals and groups at the (TIN/NPI) level.

CMS is proposing to add ten new episode-based cost measures and revising two population health measures. Specific measures of interest:

<b>Measure Topic</b>	<b>Measure Type</b>	<b>Measure Update</b>
Elective Primary Hip Arthroplasty	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Femoral or Inguinal Hernia Repair	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels	Procedural episode-based	Proposed for 2020 Performance Period and Beyond
Total Per Capita Cost	Population-Based	Revised and proposed for 2020 Performance Period and Beyond
Medicare Spending Per Beneficiary Clinician	Population-Based	Revised and Proposed for 2020 Performance Period and Beyond

*Citation:* Centers for Medicare and Medicaid Services, Medicare Program; CY 2020 Revisions to Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations.

***Improvement Activities***

CMS proposes the following changes to the Improvement Activities performance category:

- Increasing the minimum number of clinicians in a group or virtual group that are required to perform an improvement activity (for the improvement performance category) to 50 percent for the 2020 Performance Period/2022 Payment Year, and all future years.
- Requiring at least 50 percent of a group’s National Provider Identifiers (NPIs) to perform the same activity for the same 90-day period (beginning with the 2020 Performance Period/2022 Payment Year).

***Promoting Interoperability***

CMS is proposing to make the *Query of 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 is eligible for five bonus points in CY 2020.

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

New definitions:

- CMS proposes to define a hospital-based MIPS eligible clinician as an individual that furnished 75 percent or more of their professional services in an inpatient hospital, on-campus outpatient hospital, off-campus outpatient hospital, or emergency room, beginning with the 2022 Payment Year.
- CMS proposes to define a group or virtual group as hospital-based if more than 75 percent of the NPIs in the group meet the definition of a hospital-based individual MIPS eligible clinician.
  - These designations would be eligible for reweighting.

### ***Alternative Payment Models***

CMS proposes to allow clinicians in MIPS APMs to receive a quality performance category score through individual or TIN-level reporting, based on the relevant MIPS reporting and scoring rules for the quality performance category, if necessary.

### ***Qualified Clinical Data Registries***

Changes to the QCDR program:

- CMS proposes to require qualified clinical data registries (QCDRs) and qualified registries to be able to report on the Quality, Improvement Activities, and Promoting Interoperability performance categories by the 2020 Performance Period, and all subsequent years.
- CMS proposes changes to the QCDR program that requires them to foster services to clinicians and groups to help improve the quality of care they provide to patients. Some examples CMS explains are providing educational services in quality improvement and leading quality improvement activities.
  - CMS proposes to require that QCDRs detail these services during their self-nomination submission process.
- CMS proposes to require that QCDRs provide performance feedback to participating clinicians and groups at least 4 times per year, as well as feedback on how they compare with their peers on respective measures.

### ***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.

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