SIR Summary of 2020 Proposed Medicare Physician Fee Schedule (MPFS)

On July 29, 2019, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2020 Medicare Physician Fee Scheduled (MPFS) Proposed Rule. (CY) 2020 Medicare Physician Fee Scheduled (MPFS) Proposed Rule. The proposed changes were heavily geared towards following initiatives: patient-over-paperwork, reducing provider burden, substance use disorder prevention, and Medicare shared savings programs.

Payment provisions

CY 2020 PFS rate setting – There was a slight increase in the conversion factor by $0.05 points to $36.09 (CY 2020) from $36.04 (CY 2019). IR will see decreased values for bone biopsy, lumbar spine puncture, abdominal aortography, angiography and duplex scan for arterial inflow-venous outflow**.** There is a potentially mis-valued service affecting fine needle aspiration. For more details on practice expenses, please review Table 21: Proposed CY 2020 Direct PE Refinements in the CY 2020 Proposed MPFS and review Table 13 for HCPCS and CPT Codes (Exhibit A in SIR summary).

SIR disagrees with CMS proposed recommendation regarding these procedures. SIR's Coding and Reimbursement Subcommittee is preparing to strongly contest such proposed ruling.

Payment for evaluation and management (E/M) services – CMS accepted the AMA CPT recommendation for change in E/M codes and language in which an add-on code will be created to primary care and nonprocedural specialties performing ongoing care for complex conditions and chronic diseases. CMS also accepted AMA RUC recommendations for a 5-level E/M documentation for existing patients but maintain 4-levels for new patients. (Exhibit C in SIR summary). This has significant IR impact because of these components:

1. These new measures are in favor of primary care and will lead to substantial cuts from surgical and procedural specialties. It is expected for the CY of 2021; IR will experience a combined impact of 8% payment reduction (-4% E/M and -4% refined value). See Exhibit B & Exhibit D below.
2. IR's is a patient-facing procedural specialty. However, IR's (~2%) have historically performed low in proper E/M documentation as compared to other specialties such as interventional cardiology (~20%). With the potential payment reduction for IR procedures, it is vital for IR's to highly prioritize proper E/M documentation. Prior case studies from Sarah White et al, has proven that proper IR E/M documentation and appropriate billing audits can increase practice revenue by 20% with one year. For more information and resources on E/M at the SIR Toolkit page.

Global surgery codes – CMS did not accept the AMA RUC recommended changes to the global surgery codes. CMS will continue to work towards eliminating the 10- and 90-day global periods. However, CMS is in the process of gathering information on global surgery and encourages to comments on the RAND Reports on Global Surgery Data presented in the proposed rule.

SIR disagrees with CMS's refusal in accepting AMA RUC recommendations to the global surgery codes. Such as decision will lead to 5% decrease (Exhibit E in SIR summary) in reimbursement for IR services. Therefore, SIR will be commenting and providing more data to CMS pertaining to global surgery codes, in addition to supporting AMA's comment letter on this policy.

Patient-over-paperwork initiative

Review and verification of medical record documentation – CMS is requesting for more information on the proposal for broadening scope of other medical team personnel. In this new policy, licensed providers will be given the option of reviewing and verifying (sign and date) documentation written by those classified as "other medical personnel," instead of redocumenting medical record notes. SIR agrees with proposed policies associated with the patient-over-paperwork initiative. Our members will gain significant benefits from the reduction of repetitive documentation. SIR strongly believes in supporting membership in on optimizing patient-centered care. Such an initiative will also minimize workload on the radiology nurses and technicians and enhance collaborative efforts between IR's and their referring partners.

Note: "Licensed providers" are defined as physicians, physician assistants, nurse practitioners, clinical nurse specialists and certified nurse mid-wives. "Medical team personnel" are defined as other referring physicians, medical students, residents, nurses, and others medical team members.

Reducing provider burden

Physician supervision requirements for physician assistants (PA) – CMS responded positively to the data submitted by various stakeholders regarding physician burden and has proposed a flexible policy regarding physician supervision. if there are not existing state laws or regulation, this proposed policy broadens the practice scope and spectrum of physician assistants. Physicians will be allowed to sign existing notes by physician assistants instead of generating new notes for the same visit.

Care management services – this policy is heavily focused on transitional care management (TCM) in which CMS is proposing to replace a chronic care management (CCM) codes with Medicare-specific codes for specified post discharge care. The Medicare-specific codes will be used for incremental billing for additional time and resources required in complex disease management for prolonged illnesses. Within this policy, CMS will also create new coding designed for principal care management (PCM) services, which will have designations for clinicians across all specialties. SIR agrees with the proposed policies for reduced physician supervision requirements for physician assistants and new Medicare-specific codes for care management of chronic diseases.

Stark advisory opinion process – CMS is requesting for more information from all specialties regarding the provider burden associated with the compliance uncertainties of the Stark law. The current concern is that the law potentially impedes care coordination within the value-based care model. SIR encourages current members to provide comments or feedback on ways CMS can update current regulations governing the Stark law. Please send all comments directly to Miata Koroma, SIR director of economics and practice development (mkoroma@sirweb.org).

Comment solicitation on opportunities for bundled payments under the PFS – CMS is solicitating comments or recommendations for opportunities to expand on bundling of existing payment rates with the hope of aligning such options with improving the efficiency of the health services currently provided to Medicare beneficiaries.

SIR currently does not have any recommendations for new bundled payments for IR services. However, SIR members are encouraged to email comments or feedback on this policy directly to Miata Koroma, SIR director of economics and practice development (mkoroma@sirweb.org).

Substance use disorder prevention

CMS proposes **Medicare coverage for opioid use disorder treatment services furnished by opioid treatment programs (OTPs)** and is currently soliciting comments on creating a bundled episode of care for management and counseling treatments for substance use disorders.

Medicare telehealth services – CMS has created HCPCS codes as a bundled payment for telehealth services in treatment of opioid use disorders. (GYYY1, GYYY2, and GYYY3).

SIR agrees with CMS propose policies for substance use disorder prevention. SIR continues to be a strong advocate for proper management of chronic pain. The society's Pain Management Service Line has provided clinical data and evidenced-based research in support of early medically necessary minimally invasive and nonopioid interventions. SIR encourages members to provide any supporting clinical data, patient testimonials and other comments deemed important to support this patient population.

Medicare shared savings programs

CMS is soliciting comment on how to potentially align the Medicare shared savings program quality performance scoring methodology more closely with the Merit-based Incentive Payment System (MIPS) quality performance scoring methodology.

Merit-based Incentive Payment Systems (MIPS) – CMS has changed the name of this system to MIPS Value Pathways (MVP). For the calendar year of 2020, the proposed rule will make the following weight modifications:

- Cost category – increase to 20% for 2020
- Quality category – decrease to 40% for 2020, 35% in 2021 and 30% in 2022
- Promoting interoperability threshold category – same rate of 25% and hospital-based MIPS-eligible clinicians billing under groups and virtual groups will require only 75% participation for payment year 2022.
- Improvement activities category – same rate of 15%
- Performance threshold – increase to 45 points for 2020 and 60 points for 2021
- Exceptional performance threshold – increase to 80 points for 2020 and 85 points for 2021
- Minimum and maximum penalties – currently at -7% and 7%, in 2020 moved to -9% and 9%
- Low volume threshold – maintain same parameters from 2019: have $90,000 or less in Part B allowed charges for covered professional services; or provide care to 200 or fewer beneficiaries; or provide 200 or fewer covered professional services under the Physician Fee Schedule (PFS).

CMS proposes that within the 2021 year, MIPS will partner with Qualified Clinical Data Registries (QCDRs), qualified registries, and health IT vendors and encourage submission of registry data as part of the MIPS Value Pathways (MVP). SIR agrees with the proposed changes within the Medicare Shared Savings Programs. Through the utilization of QCDRs, SIR anticipates significant opportunities for benchmarking IR-specific quality measures, clinical guidelines, and appropriate use criteria (AUC). SIR will continue to review the proposed changes mentioned within the MVP modifications. A more detail feedback will be provided, during the comment period, regarding some of the quality metric proposed revisions.

SIR agrees with CMS' proposed changes which will include the following episode-based cost measures for CY 2020:

- Acute kidney injury requiring new inpatient dialysis
- Elective primary hip arthroplasty
- Femoral or inguinal hernia repair
- Hemodialysis access creation
- Inpatient chronic obstructive pulmonary disease (COPD) exacerbation
- Lower gastrointestinal hemorrhage
- Lumbar spine fusion for degenerative disease
- Lumpectomy, partial mastectomy, simple mastectomy
- Non-emergent coronary artery bypass graft (CABG)
- Renal or ureteral stone surgical treatment

Alternative payment models (APMs) – Quality measures based on an APM's measures are not always available for MIPS scoring. CMS proposes allowing APM Entities and MIPS eligible clinicians participating in APMs the option to report on MIPS quality measures for the MIPS quality performing category. APM entities will receive a calculated score based on individual, tax identification number (TIN) or APM entity reporting.

Accountable care organizations (ACOs) – CMS wants to reduce the burden on ACOs by aligning quality metrics across programs. Therefore, CMS proposes refining the current program by removing one measure from a shared savings program and adding another to the CMS web interface for the Quality Payment Program (QPP). CMS also proposes reverting one measure from the shared savings program to pay-for-reporting due to a substantive change made by the measure owner.

Other Provisions

Open payments programs – Currently, CMS openly publishes financial relationships that physicians and teaching hospitals have with applicable manufacturers and group purchasing organizations (GPO). CMS wants to make the data more useful and is proposing expanding the definition of "covered recipient," modifying payment categories, and standardizing data on reported medical devices.

Direct practice expense (PE) – Based on review conducted by StrategyGen, CMS proposes practice expense changes to address pricing outliers for equipment and supplies. These modifications will be spread over a 4-year period for roughly 70 market-based equipment and supplies.

SIR agrees with the re-evaluation and will comment on IR-related equipment and supplies that require increase pricing.

Public Comments on the proposed rules are due Sept.27, 2019.

Appendix

Exhibit A: CY 2020 Proposed MPFS TABLE 13

TABLE 13: HCPCS and CPT Codes Proposed as Potentially Misvalued

CPT/HCPCS Code	Short Description
10005	Fna bx w/us gdn 1st les
10021	Fna bx w/o img gdn 1st les
76377	3d render w/intrp postproces
G0166	Extrnl counterpulse, per tx

Exhibit B: CY 2020 Proposed MPFS TABLE 111

TABLE 111: Estimated Specialty Level Impacts of Proposed E/M Payment and Coding Policies if Implemented for CY 2021

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact*
Allergy/Immunology	$236	4%	3%	0%	7%
Anesthesiology	$1,993	-5%	-1%	0%	-7%
Audiologist	$70	-4%	-2%	0%	-6%
Cardiac Surgery	$279	-5%	-2%	-1%	-8%
Cardiology	$6,595	2%	1%	0%	3%
Chiropractor	$750	-5%	-3%	-1%	-9%
Clinical Psychologist	$787	-7%	0%	0%	-7%
Clinical Social Worker	$781	-7%	0%	0%	-6%
Colon And Rectal Surgery	$162	-3%	-1%	-1%	-4%
Critical Care	$346	-5%	-1%	0%	-6%
Dermatology	$3,541	0%	1%	-1%	-1%
Diagnostic Testing Facility	$697	-1%	-4%	0%	-4%
Emergency Medicine	$3,021	-6%	-2%	1%	-7%
Endocrinology	$488	11%	5%	1%	16%
Family Practice	$6,019	8%	4%	1%	12%
Gastroenterology	$1,713	-2%	-1%	-1%	-4%
General Practice	$405	5%	2%	0%	8%
General Surgery	$2,031	-3%	-1%	0%	-4%
Geriatrics	$187	2%	1%	0%	3%
Hand Surgery	$226	-1%	0%	0%	-1%
Hematology/Oncology	$1,673	8%	4%	1%	12%
Independent Laboratory	$592	-3%	-1%	0%	-4%
Infectious Disease	$640	-3%	-1%	0%	-3%
Internal Medicine	$10,507	2%	2%	0%	4%
Interventional Pain Mgmt	$885	4%	3%	1%	8%
Interventional Radiology	$432	-3%	-3%	0%	-6%
Multispecialty Clinic/Other Phys	$148	-2%	0%	0%	-2%
Nephrology	$2,164	-2%	0%	0%	-2%

Exhibit C: CY 2020 Proposed MPFS TABLE 116

TABLE 116: Current, RUC recommended and CMS Refined Office/Outpatient E/M Work RVUs

CPT/HCPCS	Current Work RVU (Current)	RUC-Recommended Work RVU	Alternative: CMS-Refined Work RVU
99201	0.48	NA	NA
99202	0.93	0.93	0.93
99203	1.42	1.6	1.6
99204	2.43	2.6	2.6
99205	3.17	3.5	3.5
99211	0.18	0.18	0.18
99212	0.48	0.7	0.56
99213	0.97	1.3	1.3
99214	1.5	1.92	1.81
99215	2.11	2.8	2.8
99XXX	NA	0.61	0.5
GPC1X	0.25	NA	0.33
GCG0X	0.25	NA	0.33

Exhibit D: CY 2020 Proposed MPFS TABLE 117

TABLE 117: Estimated Specialty Specific Impacts of CMS Refined Values if Implemented in CY 2020

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$236	3%	3%	0%	6%
Anesthesiology	$1,993	-3%	-1%	0%	-4%
Audiologist	$70	-2%	-1%	0%	-4%
Cardiac Surgery	$279	-3%	-1%	0%	-5%
Cardiology	$6,595	1%	1%	0%	1%
Chiropractor	$750	-3%	-2%	-1%	-6%
Clinical Psychologist	$787	-4%	0%	0%	-3%
Clinical Social Worker	$781	-4%	1%	0%	-3%
Colon And Rectal Surgery	$162	-1%	0%	0%	-1%
Critical Care	$346	-2%	-1%	0%	-3%
Dermatology	$3,541	1%	2%	-1%	2%
Diagnostic Testing Facility	$697	0%	-3%	0%	-3%
Emergency Medicine	$3,021	-3%	-1%	1%	-3%
Endocrinology	$488	5%	2%	1%	8%
Family Practice	$6,019	4%	2%	1%	6%
Gastroenterology	$1,713	0%	0%	-1%	-1%
General Practice	$405	3%	1%	0%	4%
General Surgery	$2,031	-1%	0%	0%	-2%
Geriatrics	$187	1%	1%	0%	2%
Hand Surgery	$226	0%	1%	0%	1%
Hematology/Oncology	$1,673	5%	2%	1%	8%
Independent Laboratory	$592	-2%	0%	0%	-2%
Infectious Disease	$640	-2%	0%	0%	-2%
Internal Medicine	$10,507	1%	1%	0%	2%
Interventional Pain Mgmt	$885	2%	2%	1%	4%
Interventional Radiology	$432	-1%	-2%	0%	-4%
Multispecialty Clinic/Other Phys	$148	0%	0%	0%	0%
Nephrology	$2,164	-1%	0%	0%	-1%

Exhibit E: CY 2020 Proposed MPFS TABLE 118

TABLE 118: Estimated Specialty Specific Impacts of CMS Refined Values with HCPCS add-on G code GPC1X if Implemented in CY 2020

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$236	3%	3%	0%	7%
Anesthesiology	$1,993	-5%	-1%	0%	-6%
Audiologist	$70	-4%	-2%	0%	-6%
Cardiac Surgery	$279	-5%	-2%	-1%	-7%
Cardiology	$6,595	1%	1%	0%	3%
Chiropractor	$750	-5%	-3%	-1%	-9%
Clinical Psychologist	$787	-6%	0%	0%	-6%
Clinical Social Worker	$781	-6%	0%	0%	-6%
Colon And Rectal Surgery	$162	-3%	0%	0%	-3%
Critical Care	$346	-4%	-1%	0%	-5%
Dermatology	$3,541	0%	1%	-1%	-1%
Diagnostic Testing Facility	$697	0%	-3%	0%	-4%
Emergency Medicine	$3,021	-5%	-2%	1%	-6%
Endocrinology	$488	10%	4%	1%	15%
Family Practice	$6,019	7%	3%	1%	11%
Gastroenterology	$1,713	-2%	-1%	-1%	-4%
General Practice	$405	5%	2%	0%	7%
General Surgery	$2,031	-3%	-1%	0%	-4%
Geriatrics	$187	1%	2%	0%	3%
Hand Surgery	$226	-1%	0%	0%	-1%
Hematology/Oncology	$1,673	7%	4%	1%	12%
Independent Laboratory	$592	-2%	-1%	0%	-4%
Infectious Disease	$640	-2%	0%	0%	-3%
Internal Medicine	$10,507	2%	2%	0%	4%
Interventional Pain Mgmt	$885	4%	3%	1%	8%
Interventional Radiology	$432	-2%	-3%	0%	-5%
Multispecialty Clinic/Other Phys	$148	-2%	0%	0%	-2%
Nephrology	$2,164	-2%	0%	0%	-2%
Neurology	$1,503	2%	5%	0%	8%
Neurosurgery	$802	-3%	-1%	-2%	-6%
Nuclear Medicine	$50	-3%	0%	0%	-4%
Nurse Anes / Anes Asst	$1,291	-6%	-2%	0%	-8%
Nurse Practitioner	$4,503	4%	3%	0%	7%
Obstetrics/Gynecology	$620	4%	3%	0%	7%