Physician Fee Schedule Final Rule

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What's Ahead for 2020?

On November 1, the Centers for Medicare & Medicaid Services (CMS) released the highly anticipated Final Rule for the 2020 Physician Fee Schedule (PFS). Although the PFS is specific to Medicare reimbursement, CMS' dictums have significant influence over all insurers. Perhaps the most significant changes – those made to evaluation and management (E/M) codes – will wait until next year, as the implementation date is January 1, 2021. However, the 2,475-page rule will certainly impact the coming year. The following highlights the impacts.

> Slight boosts in the unit valuation of services typically performed by clinical social workers, podiatry, urology, and obstetrics/gynecology, thus increasing the overall reimbursement for those specialties. Ophthalmology and optometry, as well as

vascular surgery and neurology, got hit with small decreases due to the re-valuing of the units associated with commonly used codes. Most specialties are projected to experience no change in the coming year.

A new Principal Care Management (PCM) code that mirrors the current Chronic Care Management (CCM) coding and reimbursement scheme, albeit requiring only a single serious, high-risk illness to use. CMS is reporting that the agency expects this code will be used by medical specialists "who are focused on managing patients with a single complex chronic condition requiring substantial care management." "We anticipate," reveals CMS, "that …PCM services will be billed when a single condition is of such complexity that it cannot be managed as effectively in the primary care setting, and instead requires management by another, more specialized, practitioner."

CCM codes will get a boost in payment, to include a new add-on code for additional time spent beyond the 20-minute monthly minimum requirement. Further, the definition of a care plan in the Complex CCM code set was relaxed: the plan can be "established, implemented, revised, or monitored."

Increased reimbursement for Transitional Care Management (TCM) codes 99495 and 99496, used for the services provided on a patient following a discharge.

Provision for a single, annual patient consent for communication technology-based services (CTBS) and inter-professional consultations.

Coverage for a multitude of opioid treatment services – to include those provided via telehealth.

Confirmation regarding the supervision requirements for physician assistants, which are being relaxed but only in the absence of state law. If state law does not otherwise dictate the requirements of supervision, CMS advises "documentation at the practice which demonstrates the working relationship that PAs have with physicians in furnishing their professional services." State-based requirements will continue to trump these new, more lenient rules if such exist.

The Quality Payment Program, which requires participation from approximately half of the country's physicians and advanced practice providers, imposes a penalty for non-compliance. The program, commonly referred to as the name of one its participation pathways – the Merit-based Incentive Payment (MIPS) System – will experience little change in the coming year. The cost category, one of four in MIPS, was supposed to rise to 20% of the weight but will remain at 15% with quality at 45%; CMS increased the exceptional performance threshold to 85 points, up from the proposed 80; and finalized new episode-based measures in the cost performance category. CMS further expressed its intention to move to MIPS Value Pathways, although the agency is still working on the details.

Last, but certainly not least, CMS backed off from its proposal to collapse payment for

E/M levels two through four. Instead, the agency opted to adopt the American Medical Association's (AMA) new guidance for E/M coding. There will no longer be a level one, new patient code (99201), although it was rarely, if ever, used. The more significant change is the fact that the performance of a history and/or exam is required only as medically appropriate and need not be incorporated as it relates to the choice of the code level. Per the AMA, "the code descriptors…state providers should perform a 'medically appropriate history and/or examination.'" Furthermore, providers can choose the E/M level based on either medical decision making or time. It is vital for all providers to become familiar with the AMA's changes as these will impact the E/M codes, which are relevant to all patients, not just Medicare beneficiaries.

In addition to these changes to the codes, office/outpatient E/M codes will get a significant boost in payment due to a revision to the relative value units that provide the foundation for payment. CMS has introduced payment for a new "prolonged services" CPT code 99XXX, for each 15 additional minutes above and beyond the highest-level E/M codes. (This new code will replace 99358-99359.) Primary care and medical specialists will get an additional payment bump by using a new, Medicare-only add-on code – GPC1X - to describe the work associated with ongoing care, although the (positive) reverberations of these alterations will have to wait for another year.

The E/M changes are being executed in 2021, but CMS proceeds in clarifying its modified documentation policy so that physicians and advanced practice providers can simply "review and verify (sign and date), rather than re-documenting, notes made in the medical record by other physicians, residents, medical, physician assistant and APRN students, nurses or other members of the clinical team."

Those highlights pale in comparison to the paltry nickel increase to the overall payment rate – after accounting for these changes and the required budget neutrality, CMS announced the payment conversion factor to be $36.09, just pennies over the current $36.04.

The quotes are extracted from CMS' Final Rule, which is on display at this link: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf.
