

## 2020 Medicare Physician Fee Schedule

### Final Rule Summary

On November 1, 2019, the Centers for Medicare & Medicaid Services (CMS) issued the Medicare Physician Fee Schedule (PFS) [final rule](#), retaining the conventional treatment delivery, IMRT and image guidance G codes through 2020. ASTRO successfully advocated for this extension as the specialty transitions to value-based payment through the pending implementation of the RO Model.

The final rule updates the payment policies, payment rates, and quality provisions for services furnished under the MPFS effective January 1, 2020. The MPFS pays for services furnished by physicians and other practitioners in all sites of service. These services include office visits, surgical procedures, diagnostic tests, therapy services, specified preventative services and more. Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for physician work, practice expense and malpractice. These RVUs become payment rates through the application of a conversion factor, which is updated annually.

### MPFS Impact Table

The MPFS Impact Table shows the estimated impact on total allowed charges by specialty of all the RVU changes. CMS estimates no significant modifications to the payment rates for radiation oncology services for 2020. CMS stated that this rate stability is designed to secure a smooth transition to [value-based payment](#) through the RO Model which is expected to occur in 2020.

**Table 119: CY 2020 PFS Estimated Impact on Total Allowed Charges by Specialty**

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
<b>Total</b>	\$93,487	0%	0%	0%	0%
<b>Radiation Oncology and Radiation Therapy Centers</b>	\$1,762	0%	0%	0%	0%

### Conversion Factor/Target

The MPFS conversion factor, based on the final 2020 rates, is set at \$36.09. This is a slight increase from the 2019 conversion factor rate update of \$36.04. The increase reflects an adjustment for budget neutrality and reflects the fact that 2020 is the first year that there is no update related to provisions found in the Medicare and CHIP Reauthorization Act (MACRA) of 2015.

**Table 117: Calculation of the CY 2020 PFS Conversion Factor**

<b>CY 2019 Conversion Factor</b>		<b>\$36.04</b>
<b>Statutory Update Factor</b>	0.00 percent (1.0000)	
<b>CY 2020 RVU Budget Neutrality Adjustment</b>	0.14 percent (1.0014)	
<b>CY 2020 Conversion Factor</b>		<b><u>\$36.09</u></b>

**Conventional Treatment Delivery, IMRT and Image Guidance Codes (G6001-G6015)**

In the 2015 MPFS final rule, CMS rejected the RUC-recommended revaluations for the radiation therapy Conventional Treatment Delivery, Intensity Modulated Radiation Therapy (IMRT) and Image Guidance Codes. CMS established G codes G6001 through G6015 to recognize the services and cross-walked their values back to the 2014 CPT codes that had been deleted.

In December 2015, the ASTRO-backed Patient Access and Medicare Protection Act (PAMPA) effectively froze the definitions, work RVUs and direct practice expense inputs for the G codes at 2016 rates through the end of 2018. Thanks to ASTRO’s advocacy efforts, the freeze was extended again through 2019 with the passage of the Bipartisan Budget Act of 2018.

In the 2020 MPFS final rule, CMS finalized its proposal to retain the conventional treatment delivery, IMRT and image guidance G codes. ASTRO is pleased with the Agency’s decision to retain the existing G Code freeze through 2020, as ASTRO advocated for the extension as the specialty transitions to value-based payment through the pending implementation of the RO Model. It would have been a significant challenge for radiation oncology practices participating in the proposed radiation oncology alternative payment model to also adjust practice patterns to account for a new code set and related values. Additionally, the Agency finalized its proposal to continue to include a 60 percent utilization rate assumption for the equipment item: ER089: “IMRT Accelerator”.

**Direct PE Inputs for Supply and Equipment Pricing – Year Two of Four Year Phase In**

In the 2019 MPFS final rule, CMS finalized its decision to update the Direct Practice Expense (PE) inputs for 1,300 supplies and 750 equipment items to be phased in over a four-year period. In the 2020 MPFS final rule, the second year of the four-year phase-in, CMS continues implementation of the update resulting in a continued negative impact on a number of radiation oncology services, particularly CPT Code 77373 SBRT Treatment Delivery.

In 2020 MPFS proposed rule comments, ASTRO expressed concern regarding the decreases in equipment pricing and urged CMS to mitigate some of the proposed reductions. While the Agency recognized ASTRO’s concerns, it did not make any modifications to the update for 2020 but rather recommended that invoices be submitted for consideration in future rulemaking.

The following chart details those radiation oncology equipment items that will experience the greatest decline in reimbursement as a result of this new policy.

Equipment Item	2018 Price	CY 2019 Final Price (Year 1)	CY 2020 Final Price (Year 2)	CY 2021 Projected Price (Year 3)	CY 2022 Projected Price (Year 4)	% Change Over 4-Year Phase-In
ER003 HDR Afterload System, Nucletron - Oldelft	\$375,000	\$314,393.70	\$253,787	\$193,181	\$132,575	-64.6%
ED033 Treatment Planning System, IMRT (Corvus w- Peregrine 3D Monte Carlo)	\$350,545	\$312,220.50	\$273,896	\$235,572	\$197,247	-43.7%
ER083 SRS System, SBRT, Six Systems, Average	\$4,000,000	\$3,743,430	\$3,486,86	\$3,230,291	\$2,973,722	-25.7%

ASTRO urges radiation oncology practices to pay close attention to the equipment prices set by Medicare in this final rule, as these prices will play a pivotal role in how CMS reimburses for treatments performed on this equipment.

**CPT Code 55874 Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed**

In the 2018 MPFS final rule, CMS finalized the establishment of CPT Code 55874 *Transperineal placement of biodegradable material, peri-prostatic, single or multiple injection(s), including image guidance, when performed*. For 2020, the non-facility PE RVUs are projected to decrease 13 percent. In the 2020 MPFS final rule, CMS confirmed that the decreases for CPT code 55874 are due to changes in the specialty mix, as the data used to value the code shifted from projected utilization to reported claims data. The Agency asserts that it is important to use actual claims data as opposed to utilization projections to value services once the data for new codes has become available.

**Evaluation and Management Code (E/M) Modifications**

In the 2019 MPFS final rule, CMS finalized changes to the documentation and billing requirements for E/M services, effective January 1, 2021. These modifications were

implemented to reduce documentation burden for physicians by allowing physicians to choose whether to use medical decision making or time when billing E/M codes. Additionally, the modifications establish a new payment structure for levels 2-4 of the E/M codes, which crosswalk each level to a single blended payment rate for office/outpatient E/M visits. The modified payment structure drew pushback from many physician groups, including ASTRO, due to concerns that the changes will lead to unintended consequences.

Under the 2020 MPFS final rule, CMS finalized modifications to the E/M codes, including the establishment of five levels of coding for established patients, reduction of the number of levels to four for new patients, and a revision to the code definitions. The finalized changes also allow clinicians to choose the E/M visit level based on either medical decision-making or time and require the collection of medical history and exam **only** when medically appropriate. These changes were developed in concert with the American Medical Association's (AMA) CPT Editorial Panel.

The MPFS adopts the AMA's RUC-recommended payment rates, which were derived from a survey of over 50 specialty societies and stakeholders. The MPFS also finalized payments based on each code descriptor to pay for each level of service, rather than utilizing a “blended rate” for E/M code levels 2 through 4 that was finalized in the 2019 MPFS final rule.

### **E/M Add-on Codes**

In the 2020 MPFS final rule, CMS establishes two add-on codes to support the new E/M coding structure. The Agency asserts that there is a need for add-on coding because the revised office/outpatient E/M code set does not recognize that there are additional resource costs inherent in furnishing some types of office/outpatient E/M visits.

#### **Add-On Code GPC1X**

In the 2020 MPFS final rule, CMS finalized HCPCS code GPC1X to be implemented January 1, 2021 to better describe the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient’s single, serious, or complex chronic condition. The chart below provides the finalized descriptor and associated times/RVU values for the revised add-on code.

**TABLE 36: Revaluation of HCPCS Add-on G code Finalized for CY 2021**

<b>HCPCS Code</b>	<b>Finalized Code Descriptor Revisions</b>	<b>FR 2019 total time (mins)</b>	<b>FR 2019 Work RVU</b>	<b>Proposed total time (mins)</b>	<b>Proposed Work RVU</b>
<b>GPC1X</b>	Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Addon code, list separately in addition to office/outpatient evaluation and management visit, new or established)	8.25	0.25	11	0.33

Prolonged Services

CMS also finalized a new "prolonged visit" code (GPRO1) in the 2019 MPFS final rule that allows physicians to receive higher payment rates for spending additional time with patients whose visits are coded at levels 2 through 4. In the 2020 MPFS final rule, CMS deleted the HCPCS add-on code GPR01 and adopted an AMA RUC recommended 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* and values without refinement.

Combined Impact

In the 2020 MPFS final rule, CMS continues to refine the E/M codes. Below is a chart displaying the potential impact on radiation oncology. According to the chart, the impact on radiation oncology is a combined reduction of 4 percent (specifically related to the E/M codes that the specialty bills, which is not a high volume). That's a 2 percent cut in Work RVU and 2 percent cut in PE RVUs associated with E/M codes that are frequently billed by radiation oncologists.

**Table 120: Estimated Specialty Level Impacts of Proposed E/M Payment and Coding Policies if Implemented in CY 2021**

(A)	(B)	(C)	(D)	(E)	(F)
Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact*
<b>Total</b>	<b>\$92,979</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>	<b>0%</b>
Radiation Oncology and Radiation Therapy Centers	\$1,756	-2%	-2%	0%	-4%

Overall, those specialties that bill higher level established patient visits, such as endocrinology or family practice, will see the greatest increases in overall impact as those codes were revalued at higher rates relative to the rest of the office/outpatient E/M code set. Those specialties that see the greatest decreases are those that do not generally bill office/outpatient E/M visits.

ASTRO, along with many stakeholders, submitted public comments expressing concern about the validity of these potential impact percentages and sought more information through rulemaking to clarify the negative impact the proposed E/M changes will have on radiation oncology payments. In the 2020 MPFS final rule, the Agency is encouraging the public to submit additional information, including RUC and stakeholder valuation recommendations to be considered in 2021 rulemaking

**Physician Supervision Requirements**

In the 2019 proposed rule, CMS recommended modifications to its regulation of physician supervision of physician assistants (PA) to give PAs greater flexibility to practice more broadly. For those states without a state law governing physician supervision of PA services, the physician supervision required by Medicare for PA services would be documented in the medical record. Such documentation would include information regarding the PA’s approach to working with physicians in providing services.

The Agency received comments expressing concern that Medicare requirement for supervision of PA services may impose a more stringent standard than state laws governing physician supervision of PA services. It was also suggested that the current regulatory definition of physician supervision, as it applies to PAs, could inappropriately restrict the practice of PAs in delivering professional services to the Medicare population.

The 2020 MPFS final rule revises this policy such that the statutory physician supervision requirement for PA services would be met when a PA furnishes services in accordance with state law and state scope of practice rules for PAs in the state in which the services are furnished, with

appropriate medical direction and supervision as required by state law. In the absence of state law governing physician supervision of PA services, documentation of physician supervision required by Medicare for PA services would be required in the medical record. Documentation includes the PA's approach and involvement in working with physicians in furnishing services. This change aligns the regulation on physician supervision for PA services with current regulations on physician collaboration for Nurse Practitioner (NP) and Clinical Nurse Specialist (CNS) services.

### **Quality Payment Program**

ASTRO will provide a separate summary on the provisions in the rule regarding updates to the Quality Payment Program including changes to the Merit Based Incentive Payment System and Alternative Payment Models.

**Additional information about the 2020 MPFS final rule can be found at the following links:**

The final rule is available online at:

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf>

The CMS Fact Sheet on the final rule is available at:

<https://www.cms.gov/newsroom/fact-sheets/finalized-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar>

Other supporting documents and tables referenced in this final rule are available through the Internet on the CMS website at: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-F.html>