

2020 Medicare Physician Fee Schedule

Proposed Rule Summary

On Monday, July 29, 2019, the Centers for Medicare & Medicaid Services (CMS) issued the Medicare Physician Fee Schedule (PFS) [proposed rule](#), agreeing with ASTRO’s recommendation to retain the treatment delivery, IMRT and image guidance G codes through 2020. The proposed rule updates the payment policies, payment rates, and quality provisions for services furnished under the MPFS effective January 1, 2020. Comments are due to CMS no later than September 27, 2019.

The MPFS pays for services furnished by physicians and other practitioners in all sites of service. These services include 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 is not proposing any significant modifications to radiation oncology services for 2020. CMS says this rate stability is designed to secure a smooth transition to [value-based payment](#), which is expected to occur in 2020.

Table 110: 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
Total	\$92,979	0%	0%	0%	0%
Radiation Oncology and Radiation Therapy Centers	\$1,756	0%	0%	0%	0%

Conversion Factor/Target

The MPFS conversion factor, based on the proposed 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.

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.

CMS is proposing in the 2020 MPFS that the G codes be retained to ensure payment stability. Additionally, the Agency is proposing to continue to include a 60 percent utilization rate assumption for the equipment item: ER089: “IMRT Accelerator”.

ASTRO thanks CMS for agreeing with [our recommendation](#) to retain the G codes. 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.

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 1300 supplies and 750 equipment items, including key equipment items related to radiation oncology. To address significant changes in payment, CMS phased in the new direct PE inputs over a four-year period.

The following chart details those radiation oncology equipment items that were proposed to experience the greatest decline in reimbursement as a result of this new policy. ASTRO opposed these proposed changes and helped to mitigate some of the initially proposed reductions.

	2019 Price	2020 Price
ED033 Treatment Planning System, IMRT (Corvus w-Peregrine 3D Monte Carlo)	\$312,220.50	\$273,896
ER003 HDR Afterload System, Nucletron - Oldelft	\$314,393.70	\$253,787.39
ER083 SRS System, SBRT, Six Systems, Average	\$3,743,430.46	\$3,486,860.92
ES052 Brachytherapy Treatment Vault	\$179,528.56	\$184,057.13

As anticipated, the continuation of the modification to the prices for specific supplies and equipment has a negative impact on the PE RVUs for a number of radiation oncology services, particularly CPT Code 77373 *SBRT Treatment Delivery*, which is proposed to experience a 7.25 percent reduction in PE RVUs.

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. CMS stated, “these policies would allow practitioners greater flexibility to exercise clinical judgment in documentation so they can focus on what is clinically relevant and medically necessary for the beneficiary.” CMS retained the existing E/M CPT code structure, which denote specific levels of care; however, the new payment structure of levels 2-4 of the E/M codes will be cross-walked to a single blended payment rate for office/outpatient E/M visit, a move that drew pushback from many physician groups, including ASTRO, that worried the changes could lead to unintended consequences.

Under the 2020 MPFS proposed rule, CMS proposes to implement modifications to the E/M codes that will be implemented January 1, 2021. CMS proposes to retain five levels of coding for established patients, reduce the number of levels to four for new patients, and revise the code definitions. The proposed changes also revise the times and medical decision-making process for all the E/M codes and require the collection of medical history and exam only when medically appropriate. These CPT code changes also allow clinicians to choose the E/M visit level based on either medical decision-making or time. These proposed changes were largely developed in concert with the American Medical Association's (AMA) CPT Editorial Panel.

CMS proposes to adopt the AMA's RUC-recommended payment rates, which were derived from a survey of over 50 specialty societies and stakeholders. CMS proposes 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.

In the 2019 MPFS final rule, CMS finalized a series of adjustments to capture the variety of resource costs associated with different types of care provided in E/M visits. These included the establishment of GCG0X *Visit Complexity Inherent to Evaluation and Management* and GPRO *Prolonged Evaluation and Management or Psychotherapy Service(s)*. In the 2020 MPFS proposed rule, CMS supports the establishment of add-on codes, stating that “there is still 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 kinds of office/outpatient E/M visits.” However, CMS proposes to revise the descriptor for HCPCS code GPC1X and delete HCPCS code GCG0X, consolidating the two add-on codes into a single add-on code and revising the single code descriptor 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 revised descriptor and associated times/RVU values for the revised add-on code.

TABLE 28: Proposed Revaluation of HCPCS Add-on G code Finalized for CY 2021

HCPCS Code	Proposed Code Descriptor Revisions	FR 2019 total time (mins)	FR 2019 Work RVU	Proposed total time (mins)	Proposed Work RVU
GPC1X	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

Additionally, CMS implemented a new "prolonged visit" code (GPRO1) in the 2019 MPFS final rule that allowed physicians to receive higher payment rates for spending additional time with patients whose visits are coded at level 2 through 4. In the 2020 MPFS proposed rule, CMS proposes to accept the AMA RUC recommended values for CPT code 99XXX without refinement. The RUC provided a recommendation for a new 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*). CMS proposes to delete the HCPCS add-on code finalized in last year's proposed rule for extended visits (GPRO1) and adopt the new CPT code 99XXX. CMS is seeking comment from the public and stakeholders regarding these proposed changes.

In the 2020 MPFS proposed rule, CMS continues to refine the E/M proposal and include a chart displaying the potential impact by specialty. Although CMS is not proposing changes to E/M coding and payment for 2020, the Agency is proposing certain changes for 2021. CMS believes these estimates provide insight into the magnitude of potential changes for certain physician specialties.

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Table 111: 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*
Total	\$92,979	0%	0%	0%	0%
Radiation Oncology and Radiation Therapy Centers	\$1,756	-2%	-2%	0%	-4%

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 significant 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.

Physician Supervision Requirements

CMS is proposing to modify its regulation of physician supervision of physician assistants (PA) to give PAs greater flexibility to practice more broadly. The Agency is proposing that 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.

Calculation of GPCI and Malpractice RVUs

For 2020, CMS is conducting the statutorily required three-year review of the Geographic Price Cost Index (GPCI), which coincides with the statutorily required five-year review of the Malpractices (MP) RVUs. The MP premium data is used to update the MP GPCIs are the same data used to determine the specialty-level risk factors, which are used to calculate the MP RVUs.

The Agency is proposing to permanently align the update of the MP premium data used to determine the MP RVUs with the update to the MP GPCI. If aligned, the new statutorily required update would be by 2023.

For the 2020 update, CMS is proposing the following improvements to the MP premium data:

- Downloading and using a broader set of filings from the largest market share insurers in

each state, beyond those listed as “physician” and “surgeon” to obtain a more comprehensive data set.

- Combining minor surgery and major surgery premiums to create the surgery service risk group, which yields a more representative surgical risk factor.
- Utilizing partial and total data points to develop a more comprehensive data set when CMS specialty names are not distinctly identified in insurer filings.

In instances where insurers report data for some, but not all specialties that explicitly corresponded to a CMS specialty, where those data were missing, CMS proposes to use partial imputation based on available data to establish what the premiums would likely have been had that specialty been delineated in the filing. In instances where there are no data corresponding to a CMS specialty in the filing, they propose to use total imputation to establish premiums.

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 proposed 2020 MPFS can be found at the following links:

To view the 2020 Physician Fee Schedule proposed rule, please visit:

<https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-16041.pdf>

For a fact sheet on the 2020 Physician Fee Schedule proposed rule, please visit:

<https://www.cms.gov/newsroom/fact-sheets/proposed-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-2>

For 2020 Physician Fee Schedule proposed rule data files, appendices and other materials, please visit:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1715-P.html>