Key Provisions of the 2020 Medicare Physician Fee Schedule Final Rule

The Centers for Medicare & Medicaid Services (CMS) published its 996-page 2020 Medicare Physician Fee Schedule Final Rule November 15, 2019. CMS estimates that total allowed charges under the Medicare Physician Fee Schedule for all specialties will exceed $93 billion in 2020.

Ambulatory Care Management. Noting that only 9% of Medicare fee-for-service beneficiaries presently receive ambulatory care management services, CMS is making several important changes to expand access to these services. Our examination of changes to transitional care management, chronic care management, and remote patient monitoring are the subject of this article.

Conversion Factor. The allowable charge for each service listed on the Medicare Physician Fee Schedule is calculated by multiplying the relative value units (RVUs) assigned to that service by a standard Medicare conversion factor. In 2020, physicians will see a 0.14% increase in that conversion factor, from $36.04 in 2019 to $36.09. The calculation of the annual conversion factor is mandated under the Medicare Access and CHIP Reauthorization Act of 2015.

RVU Updates. As is the case each year, a significant portion of the Final Rule addresses work, practice expense, and malpractice RVU adjustments for a wide range of services. The 2020 RVU updates will result in minor changes in total allowed charges for some specialties, as illustrated below:
All other specialties will experience no more than a 1% gain or loss in total allowed charges due to RVU changes. Keep in mind that CMS estimates are based on the entire specialty, and the impact of the proposed RVU changes can vary widely depending on the mix of services provided in a practice.

**2021 E/M Changes.** CMS remains on track to overhaul documentation and payment policies for evaluation and management (E/M) services. Effective January 1, 2021, CMS will adopt [revised E/M code definitions developed by the AMA CPT Editorial Panel](https://www.ama-assn.org/cpt). CMS also intends to pay for each level of service rather than utilize a blended rate and to adopt revised work and practice RVU inputs for E/M services.

CMS included in the Final Rule its estimated impact of the E/M changes on specific specialties’ total allowed charges in 2021, which range from a 16% increase for endocrinologists to a 10% decrease for ophthalmologists.
### Interventional Pain Management

<table>
<thead>
<tr>
<th>Intervential Pain Management</th>
<th>8%</th>
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</thead>
<tbody>
<tr>
<td>Physical/Occupational Therapy</td>
<td>-8%</td>
</tr>
<tr>
<td>General Practice</td>
<td>8%</td>
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<tr>
<td>Nurse Practitioner</td>
<td>8%</td>
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</tbody>
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Source: CY2020 Medicare Physician Fee Schedule Final Rule, Table 120

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**Merit-Based Incentive Payment Program (MIPS).** After proposing otherwise, CMS has decided to assign the same weights to the four MIPS performance categories as it did in 2019: Quality 45%; Improvement Activities 15%; Promoting Interoperability 25%; and Cost 15%. By statute, the weighting of the Cost category must be increased to 30% and the Quality category’s weight must be reduced to 30% by 2022.

In 2020, the minimum performance score required to avoid any MIPS penalty will increase from 30 to 45 points. In 2021, it will increase to 60 points. The threshold to qualify for the exceptional performance payment will increase to 75 points in 2020 and to 85 points in 2021. Finally, the maximum incentive payment and penalty will increase to 9% in 2020.

Regarding the Cost category in particular, there will be 20 measures in 2020: the Medicare Spending Per Beneficiary measure, the Total Per Capita Costs measure, and eighteen episode-based measures. CMS is adding 10 new episode-based measures in 2020:

- Acute Kidney Injury Requiring New Inpatient Dialysis
- Elective Primary Hip Arthroplasty
- Femoral or Inguinal Hernia Repair
- Hemodialysis Access Creation
- Inpatient COPD Exacerbation
- Lower Gastrointestinal Hemorrhage
Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels

Lumpectomy Partial Mastectomy, Simple Mastectomy

Non-Emergent CABG

Renal or Ureteral Stone Surgical Treatment

In the Final Rule, CMS discussed at length its intent to expand the number of episode-based measures in future years to include more specialties, including the process for developing and validating those measures.

CMS will calculate a Cost score based on a combination of all the Cost measures for which a physician or group qualifies. However, CMS will not calculate a score in the Cost category if the physician or group does not meet the case minimum for at least one of the measures. In those cases, the 15% Cost category weight will be transferred to the Quality category, raising the percentage from 45% to 60%.

**MIPS Value Pathways.** This summer, [CMS proposed](#) an updated framework for MIPS called MIPS Value Pathways, or MVPs. The proposed MVPs are best described as condition- or specialty-specific groups of cost, quality, and improvement measures. Measures would be pre-selected and grouped for providers, to relieve the burden of choice and re-focus the program on the most important health priorities (i.e., quality over quantity).

In the Final Rule, CMS affirmed its intent to move forward with MVPs, with at least some MVPs defined and available for reporting in 2021. However, CMS offered no additional details, other than to state its intent to engage stakeholders in the MVP development process.

**Appropriate Use.** In 2020, CMS’ Appropriate Use program will move to the Educational and Operations Testing Period. CMS will expect a provider submitting a claim for advanced diagnostic imaging services (including computed tomography, positron emission tomography, nuclear medicine, and magnetic resonance imaging) furnished in a physician office, outpatient hospital department (including an emergency room), or an ambulatory surgery center to append to the claim documentation that the ordering clinician consulted a qualified Clinical Decision
Support Mechanism (CDSM).

A CDSM is an interactive, electronic tool that tells the clinician whether an order meets appropriate use criteria (AUC), does not meet AUC, or if there is no AUC applicable (e.g., no AUC is available to address the patient’s clinical condition) in the CDSM consulted.

For 2020, submission of AUC documentation will not be a condition of Medicare payment. CMS, however, remains on target to fully implement the Appropriate Use program (i.e., deny payment based on failure to submit required documentation) on January 1, 2021. Thus, providers should use this Educational and Operations Testing Period to develop and refine their processes to comply with Appropriate Use requirements. For a detailed explanation of those requirements, please refer to this MLN Matters article.

If you would like more information about the Final Rule or any of the subjects covered previously, or would like assistance with any matter involving strategy and integration, compliance, or valuation, contact one of our PYA executives below at (800) 270-9629.

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