Medicare RBRVS Changes in 2020

Conversion Factor for 2020

On November 1, 2019, the Centers for Medicare & Medicaid Services (CMS) released the Final Rule for the calendar year (CY) 2020 Medicare Physician Payment Schedule (MFS). To calculate the CY 2020 Medicare conversion factor (CF), CMS applied a budget-neutrality adjustment of 0.14%. This increase of 0.14%, effective January 1, 2020, results from the implementation of RUC recommendations for misvalued services. The CY 2020 Medicare CF is $36.0896. Effective January 1, 2020, the anesthesia CF is $22.2016, which reflects the same overall positive adjustment of 0.14%, as well as additional adjustments due to an update to practice expense (PE) and the malpractice risk factor for anesthesiology.

Coding Changes and Work Relative Values

Over the last 29 years, the American Medical Association (AMA)/Specialty Society Relative Value Scale Update Committee (RUC) has reviewed nearly all services paid through the Medicare Physician Payment Schedule, accounting for 98% of spending. For the 2020 MFS, the RUC submitted 301 recommendations for individual Current Procedural Terminology (CPT®) codes, and CMS implemented the recommended work values for 79% of these services. The coding changes for which RUC made recommendations for the CY 2020 payment schedule included transitional care management services, emergency department visits, and online digital evaluation service (e-visit). The CPT Editorial Panel (Panel) and RUC have implemented processes to improve transparency within the MFS by the early release of new CPT codes and RUC recommendations. CMS now publishes all CPT codes and their proposed relative value changes in the July Proposed Rule to enable and allow public comments prior to their implementation on January 1. RUC recommendations and supporting documentation are available at www.ama-assn.org/about/rvs-update-committee-ruc/ruc-recommendations-minutes-voting.

Important Changes to E/M Office Visits in 2021

On November 1, 2019, CMS finalized a historic provision in the 2020 MFS Final Rule. This provision includes revisions to the Evaluation and Management (E/M) office visit CPT codes (99201-99215), code descriptors and documentation standards that directly address the continuing problem of administrative burden for physicians in nearly every specialty, from across the country. With these landmark changes, as approved by the CPT Editorial Panel, documentation for E/M office visits will now be centered around how physician think and take care of patients and not on mandatory standards that encouraged copy/paste and checking boxes.

Administrative Burden Relief Implemented by CMS in 2019

The AMA's proposal to reduce administrative burden achieves a shared goal with CMS, truly putting patients over paperwork and improving the health system. These revisions work in lock step with the already established administrative burden relief initiatives established by CMS for 2019:

- Elimination of the requirement to document medical necessity of furnishing visits in the home rather than office.

- Elimination of the requirements for clinicians to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated. Physicians must only document that they reviewed and verified information regarding the chief complaint and history that is already recorded by ancillary staff or the patient.

Summary of E/M Office Visit Revisions for 2021

1. Eliminate history and physical as elements for code selection: While the physician's work in capturing the patient's pertinent history and performing a relevant physical exam contributes to both the time and medical decision making, these elements alone should not determine the appropriate code level. The workgroup revised the code descriptors to state providers should perform a "medically appropriate history and/or examination."

2. Allow physicians to choose whether their documentation is based on Medical Decision Making (MDM) or Total Time Spent on the Date of the Patient Encounter:

    - *MDM:* The Workgroup did not materially change the three current MDM sub-components, however edits were made to the elements for code selection and revised/created numerous clarifying definitions in the E/M guidelines.

    - *Time:* The definition of time is minimum time, not typical time, and represents total physician/qualified health care professional (QHP) time on the date of service. The use of date-of-service time builds on the movement over the last sev-

eral years by Medicare to better recognize the work involved in nonface-to-face services like care coordination. These definitions only apply when code selection is primarily based on time and not MDM.

3. Deletion of CPT code 99201: The Panel agreed to eliminate 99201 as 99201 and 99202 are both straightforward MDM and only differentiated by history and exam elements.

4. Creation of a shorter prolonged services code: The Panel created a shorter prolonged services code that would capture physician/QHP time in 15-minute increments. This code would only be reported with 99205 and 99215 and be used when time was the primary basis for code selection.

For more details and the following valuable resources visit www.ama-assn.org/cpt-office-visits:

- CPT 2021 E/M office or other outpatient and prolonged services codes and guideline changes
- RUC recommendations on CPT E/M office visit codes
- Educational module providing an overview of the new E/M code revisions and details on how they will differ from current coding requirements and terminology
- A practice checklist and tips to help prepare for the 2021 transition
- Sign up for E/M code revision updates from the AMA

Care Management Services

Coding and Payment for care management services are important priorities for CMS and the AMA. A number of improvements will be implemented in 2020.

Transitional Care Management

CMS examined studies that conclude that patients who receive transitional care management (TCM) services have lower hospital readmission rates, lower mortality, and incur lower costs. Based on these findings, CMS seeks to increase the utilization of TCM services and expand payment for care management. To incentivize additional utilization, billing requirements will be modified to allow TCM codes (99495 and 99496) to be reported concurrently with other codes. CMS also finalized its proposal to increase payment for the two TCM codes as recommended by RUC.

Chronic Care Management

CMS finalized its proposal to implement one new add-on code for noncomplex chronic care management (CCM) services (HCPCS G2058), which will allow providers to report time incrementally to reflect additional clinical staff time resources that are required in certain cases. However, CMS did not finalize its proposals to create G-codes for the complex CCM codes, due to the ongoing work of the CPT Editorial Panel in this area.

Principal Care Management

CMS finalized the creation of two new codes for principal care management (PCM) services (HCPCS G2064 and G2065), which will pay physicians for providing care management to patients with a single serious and high-risk condition. The current CCM codes require patients to have two or more chronic conditions. As part of its rationale, CMS cites proposals submitted to the Physician-focused Payment Model Technical Advisory Committee for managing patients with one serious chronic condition. CMS estimates an additional $125 million in annual spending for these services, offset by reductions to the Medicare conversion factor.

Self-Measured Blood Pressure Monitoring

Medicare will cover two new codes to describe self-measured blood pressure (BP) monitoring services (99473 and 99474) and to differentiate self-measured BP monitoring services from ambulatory BP monitoring.

E-Visit Services

For CPT 2020, the CPT Editorial Panel deleted codes 99444 and 98969 (the online E/M codes) and replaced them with six new nonface-to-face codes for online digital evaluation services or e-visits. These are patient-initiated digital communications that require a clinical decision that otherwise would have been typically provided in the office. Three codes describe the physician e-visit (99421, 99422, and 99423) and three codes describe the qualified nonphysician health care professional e-visit (98970, 98971, and 98972). CMS will make separate payment for the physician e-visit services (99421, 99422, and 99423); however, CMS disagreed with the CPT Editorial Panel that codes 98970, 98971, and 98972 could be performed by qualified nonphysician health care professionals based on statutory requirements that govern the Medicare benefit and do not allow nonphysicians to report E/M services. CMS created parallel HCPCS G-codes with descriptors that refer to the performance of an "assessment" rather than an "evaluation." For 2020, CMS will provide separate payment for the nonphysician online digital assessments with HCPCS G-codes G2061, G2062, and G2063.

Medicare Telehealth

CMS will cover three new telehealth codes, which describe a bundled monthly episode of care for treatment of opioid use disorders (CMS finalized the codes as G2086, G2087 and G2088). This treatment includes care coordination, individual therapy, and group therapy and counseling.

Potentially Misvalued Services

In 2006, RUC established the Relativity Assessment Workgroup (RAW) to identify potentially misvalued services using objective mechanisms for re-evaluation. Since its inception, the Workgroup and CMS have identified 2,538 services using 20 screening criteria that resulted in further review by RUC. In addition, RUC has charged RAW with maintaining the "new technology" list of services that will be re-reviewed by RUC as reporting and cost data become available. Of the 2,538 codes identified since 2006, many have been referred to the CPT Editorial Panel for revision, deletion, or creation of new codes: 2,430 have been reviewed by RUC to date. A majority of the new and revised CPT codes for 2020 are a result of the effort to improve the coding and valuation of physician services. RUC's efforts for 2009–2020 have resulted in more than $5 billion in annual redistribution within the MFS.

Geographic Practice Cost Index

As required by law, CMS adjusts payments under the PFS to reflect local differences in the costs of operating a medical practice. The 2020 geographic practice cost indices (GPCIs) will reflect the application of the statutorily mandated 1.50 work GPCI floor in Alaska and the 1.00 PE GPCI floor for all frontier states (Montana, Nevada, North Dakota, South Dakota, and Wyoming). The Bipartisan Budget Act of 2018 amended the statute to extend the 1.0 floor for the work GPCIs only through December 31, 2019. Therefore, at the time of this publication, work GPCIs do not reflect the 1.0 work floor. Some localities will experience significant decreases in their physician work GPCI based on this update.

MACRA 2015 and Medicare's Quality Payment Program

The following two pathways are offered to physicians for Medicare payment under the Medicare Access and Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA):

- A modified fee-for-service system known as the merit-based incentive payment system, which is based on traditional Medicare, and
- Alternative payment models.

Physicians can choose the pathway that suits their practices best. Visit the AMA's "Understanding Medicare Payment Reform" webpage to access a variety of helpful resources, including:

- Summaries, fact sheets, preparation checklist, and PowerPoint presentations, all of which are designed to explain and help prepare for the various components of the new Medicare payment rules.
- Links to resources and technical assistance prepared by CMS.
- Links to AMA podcast interviews with experts available through ReachMD.
- The AMA Payment Model Evaluator tool, which provides educational resources, a brief assessment to discover where a practice stands under MACRA, and actionable resources to maximize success. This model will be updated and expanded as the new payment rules evolve.
- Modules in the AMA's STEPS Forward™ practice improvement strategies series available at www.ama-assn.org/practice-management/medicare/quality-payment-program-qpp-specifics, which help practices maximize preparedness for quality reporting, prepare for value-based care, choose the best electronic health record (EHR) for the practice, and implement an EHR system.◆