ENDOCRINE SOCIETY
Hormone Science to Health

CY 2020 PHYSICIAN FEE SCHEDULE FINAL RULE SUMMARY

On November 1, the Center for Medicare and Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) final rule for 2020. This rule updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the RVUs for each CPT code can be found here. The rule's provisions will be effective January 1, 2020 unless stated otherwise. The following summarizes the major provisions of the rule.

Conversion Factor and Specialty Impact – page 1891

The conversion factor for 2020 is $36.0896, an increase of only 5 cents from 2019. Table 119 (see Appendix A), extracted from the rule, provides a summary of the impact of the changes in the proposed rule by specialty. The changes in the rule are budget-neutral in the aggregate, which explains why the impact for all physicians is shown as zero. The final rule shows changes in the range of minus 4 percent to plus 4 percent with endocrinology estimated to see no change in reimbursement.

Attached to this summary are charts showing the impact of the final rule's policy on endocrinology specific and evaluation and management (E/M) codes. Their values are relatively stable.

Payment for Evaluation and Management Visits – page 857

For CY 2021, CMS finalized significant changes to the documentation and payment of outpatient E/M services. The agency began exploring changes to the code family in the CY 2019 rulemaking in response to stakeholder concerns that the 1995/1997 E/M documentation guidelines were administratively burdensome. The AMA CPT Editorial Panel revised the E/M code definitions and document requirements over the last year to create an alternative to CMS' policy to create a single payment for level 2 through 4 E/M services with reduced documentation requirements, which the medical community unanimously opposed. CMS adopted both the changes made by the CPT Editorial Panel and RUC recommended values for these services. However, the agency will have the opportunity to further refine this policy in the CY 2021 rulemaking cycle.

CMS estimates the specialty level impact of these E/M changes should they be implemented without changes in CY 2021. They can be found in Appendix B, which includes Table 120

2055 L Street NW
Suite 600
Washington, DC
20036

T. 202.971.3636
F. 202.736.9705

endocrine.org

extracted from the rule. CMS estimates these changes will result in a 16 percent increase for endocrinology.

A detailed description of the E/M policies finalized in this rule for implementation in 2021 follows:

E/M PAYMENT: CMS will retain separate payment for the individual E/M services as revised by the CPT Editorial Panel. This includes the elimination of CPT code 99201. CMS proposes to adopt all of the RUC-recommended work RVUs and times for the revised code family and new prolonged add-on code that were based on a survey of over 50 specialty societies. CMS believes these values more accurately account for the time and intensity of these services than the policy finalized in last year's rule. The agency will consider how to minimize the negative redistributive effect of these changes in future rulemaking.

E/M Payment Comparison			
Visit Level	**Current Payment***	**Final Work RVUs**	**Proposed Payment****
99201	$45	N/A – Code would be eliminated	N/A – Code would be eliminated
99202	$76	0.93	$77
99203	$110	1.60	$119
99204	$167	2.60	$177
99205	$211	3.50	$232
99211	$22	0.18	$24
99212	$45	0.70	$60
99213	$74	1.30	$96
99214	$109	1.92	$136
99215	$148	2.80	$190
99XXX (New prolonged service)	N/A	0.61	$34.60
GPC1X (New Complexity Add-on)	N/A	0.33	$18.02

**Current payment for CY 2019*
*** Estimated payment based on the relative value units and the CY 2019 conversion factor.*

DOCUMENTATION: CMS will implement the documentation requirements that were included in the CPT Editorial Panel's revisions to the code set in 2021. They allow physicians to select a code level based on time or medical decision-making and eliminate the history and physical exam as required elements to select a code level. Documentation of these elements must be specific to each code level. Detailed information about these requirements can be found here.

CMS shares the concerns expressed by commenters about potential shifts in billed visit levels and among specialties that may result and will monitor the claims to assess changes. They will continue to consider additional refinements. The agency also will consider how to address the differing sets of E/M documentation requirements across different sites of service in future rulemaking.

PROLONGED SERVICE: CMS will pay separately for prolonged outpatient E/M services using the new CPT add-on code 99XXX and will delete GPRO1 which had been finalized last year for such services. This code will only be available when physicians choose to document based on time and the time for a level 5 visit is exceeded by 15 minutes or more on the date of service. This service could be billed multiple times for each additional 15-minute increment beyond the level 5 visit time. The agency adopted the RUC-recommended work RVU for this service.

The agency also finalized its proposal not to allow CPT codes 99358-9 (Prolonged E/M without Direct Patient Contact) to be billed in conjunction with outpatient E/M visits beginning in 2021 to be consistent with the E/M survey instructions that required practitioners to consider all time spent 3 days prior to, or 7 days after the visit.

COMPLEXITY ADD-ON CODE: Last year, CMS finalized a policy to create two add-on codes, one for primary care and another for types of complex specialty care. CMS still does not believe the code set as revised by the CPT Editorial Panel adequately describes or reflects the resources required for primary care and certain types of primary and specialty care. In the rule, the agency recognizes three types of outpatient E/M care: "(1) separately identifiable office/outpatient E/M visits furnished in conjunction with a global procedure; (2) primary care office/outpatient E/M visits for continuous patient care; and (3) certain types of specialist office/outpatient visits." In this rule, the agency consolidated these two services into a single add-on code with a revised descriptor to better describe the work associated with 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 descriptor for GPC1X has been revised as follows:

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 condition.

CMS finalized a work RVU of 0.33 and physician time of 11 minutes. These codes will be billable with any level outpatient E/M service. The agency finalized this policy despite receiving comments that recommended that this add-on code only be used to account for the additional work associated with "outlier" cases.

Global Surgical Packages
CMS finalized its policy to reject the RUC's recommendation to apply the outpatient E/M visit increases to the 10- and 90-day global services. They stated "bundled post-operative visit RVUs do not directly contribute a certain number of RVUs to the valuation of procedures with 10- or 90-day global periods". CMS does not want to make any changes to the global periods until they have accurate information about the resources required, including work, PE and malpractice, to deliver them, as well as accurate information on the post-operative services that are delivered to patients.

Congress directed CMS to collect data to value surgical services and prohibited the agency from converting all of the 10- and 90-day global packages to 0-day global packages. CMS contracted with RAND to collect this data and discussed the results of this study. RAND provided three reports to CMS, which can all be found here. CMS will be considering the approach outlined by RAND to revalue surgical procedures as well as other alternatives in future rulemaking.

Request for Comment on Revaluing Outpatient E/M Visits within Transitional Care Management (TCM), Cognitive Impairment Assessment/Care Planning and Similar Services
CMS identified a number of services that are closely tied to E/M values in addition to the surgical global services for re-evaluation. These services are:

- Transitional Care Management Services (CPT codes 99495-6)
- Cognitive Impairment Assessment and Care Planning (CPT code 99483)
- Certain ESRD monthly services (CPT codes 90951-61)
- Initial Preventive Physical Exam (G0438)
- Annual Wellness Visit (G0439)

The agency requested comment in the proposed rule on a policy to adjust the RVUs for these services and on systemic adjustments that may be needed to maintain relativity

between these services and outpatient E/M services. They note some of these services always include an outpatient E/M visit provided by the practitioner as part of the service or were valued using a direct crosswalk to an outpatient E/M service. CMS also requested comment on whether it would be beneficial to make adjustments to E/M codes for visits in other settings, including home care visits, or to codes describing more specific kinds of services, like counseling visits. The agency received a number of comments on how to address these services and will address these in future rulemaking.

Care Management Services - Page 390

Besides addressing the outpatient E/M code valuations and documentation requirements, CMS separately addressed care management services, those codes designed to improve care management and coordination. The agency finalized policies to improve the existing transitional care management (TCM), chronic care management (CCM) and chronic care remote physiologic monitoring (RPM) services. The agency also finalized new codes for principal care management (PCM) services, which are for the care management of patients having a single, serious, or complex chronic condition.

Transitional Care Management Services: TCM services are designed to capture the care required to manage a patient's transition from an inpatient hospital setting to a community setting. It covers the care delivered in the 30-day period that begins on the patient's discharge date. CMS believes that increasing the utilization of TCM services may improve patient outcomes. Based on this goal and public comments received on the proposed rule, the agency revised the billing requirements for TCM services to allow 14 codes previously prohibited from being billed concurrently with TCM to be separately billed and reimbursed. See Table 20 extracted from the rule below for this list of services.

TABLE 20: 14 HCPCS Codes that Currently Cannot be Billed Concurrently with TCM by the Same Practitioner and are Active Codes Payable by Medicare PFS

Code Family	HCPCS Code	Descriptor
Prolonged Services without Direct Patient Contact	99358	Prolonged E/M service before and/or after direct patient care; first hour; non-face-to-face time spent by a physician or other qualified health care professional on a given date providing prolonged service
	99359	Prolonged E/M service before and/or after direct patient care; each additional 30 minutes beyond the first

		hour of prolonged services
Home and Outpatient International Normalized Ratio (INR) Monitoring Services	93792	Patient/caregiver training for initiation of home INR monitoring
	93793	Anticoagulant management for a patient taking warfarin; includes review and interpretation of a new home, office, or lab INR test result, patient instructions, dosage adjustment and scheduling of additional test(s)
End Stage Renal Disease Services (patients who are 20+ years)	90960	ESRD related services monthly with 4 or more face-to-face visits per month; for patients 20 years and older
	90961	ESRD related services monthly with 2-3 face-to-face visits per month; for patients 20 years and older
	90962	ESRD related services with 1 face-to-face visit per month; for patients 20 years and older
	90966	ESRD related services for home dialysis per full month; for patients 20 years and older
	90970	ESRD related services for dialysis less than a full month of service; per day; for patient 20 years and older
Interpretation of Physiological Data	99091	Collection & interpretation of physiologic data, requiring a minimum of 30 minutes each 30 days
Complex Chronic Care Management Services	99487	Complex Chronic Care with 60 minutes of clinical staff time per calendar month
	99489	Complex Chronic Care; additional 30 minutes of clinical staff time per month

Care Plan Oversight Services	G0181	Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities within a calendar month; 30+ minutes
	G0182	Physician supervision of a patient receiving Medicare-covered hospice services (Pt not present) requiring complex and multidisciplinary care modalities; within a calendar month; 30+ minutes

CMS also identified two chronic care management codes, CPT codes 99490 and 99491, as codes that fit this policy of codes that can be billed concurrently with TCM when relevant and medically necessary. CPT 99490 is for chronic care management services of at least 20 minutes of clinical staff time for patients with multiple chronic conditions. CPT 99491 is for chronic care management services of at least 30 minutes of clinical staff time for patients with multiple chronic conditions. The agency finalized for both TCM codes the proposed increases in work RVUs and the RUC-recommended direct PE inputs, and will use future rulemaking to further refine billing practices.

- Chronic Care Management (CCM) Services: CCM services are comprehensive care coordination services furnished by a physician or non-physician practitioner (NPP) and their clinical staff for managing the overall care of a patient with two or more serious chronic conditions. These services can be billed once per calendar months. Currently, there are two subsets of codes: one for non-complex chronic care management and one for chronic care management. CMS believes that refinement of these codes is necessary to improve payment accuracy, reduce unnecessary burden, and help ensure that beneficiaries who need these services will continue to have access to them.

Non-Complex CCM Services by Clinical Staff (CPT code 99490, HCPCS code GCCC1 and GCCC2)

There is currently one CPT code for non-complex CCM: CPT code 99490 which describes 20 or more minutes of clinical staff time spent in chronic care management. CMS proposed two new G-codes with new increments of clinical staff time that can be billed with CPT code 99490.

- GCCC1 describes the initial 20 minutes of clinical staff time and is proposed to have 0.61 work RVU.

- GCCC2 describes each additional 20 minutes and is proposed to have 0.54 work RVU.

After reviewing public comments, CMS is not finalizing the proposal to create HCPCS codes GCCC1 due to concerns about increased administrative burden and the CPT Editorial Panel's ongoing work in this area. The agency is finalizing GCCC2, henceforth referred to as G2058, since this code addresses a gap in the current code set and will not create additional administrative burden. HCPCS code G2058 will be reportable by clinical staff a maximum of two times within a given service period of one calendar month for a beneficiary.

Complex CCM Services (CPT codes 99487 and 99489, HCPCS Codes GCCC3 and GCCC4)

The complex CCM services describe care management for patients whose care requires both clinical staff time and complex medical decision-making. The current CPT codes 99487 and 99489 include a requirement to establish or substantially revise a comprehensive care plan. CMS did not finalize the proposal to create HCPCS codes GCCC3 and GCCC4 in light of the CPT Editorial Panel's ongoing work in this area. The agency will continue to recognize CPT codes 99487 and 99489 but with a different care planning element for purposes of billing Medicare. Starting in CY 2020, CMS will interpret the code descriptor "establishment or substantial revision of a comprehensive care plan" to mean that a comprehensive care plan is established, implemented, revised or monitored. This change will allow for consistency in the care planning service element of complex CCM and non-complex CCM services provided by clinical staff.

CCM Services - Typical Care Plan

CMS finalized the proposal to simplify the definition of, and requirements for, a typical care plan as included in CCM services. The agency anticipates that this change will reduce burden and simplify the important work of interacting and coordinating with resources external to the practice. The new language will read as follows:

The comprehensive care plan for all health issues typically includes, but is not limited to, the following elements:

- Problem list
- Expected outcome and prognosis
- Measurable treatment goals.
- Cognitive and functional assessment.
- Symptom management
- Planned interventions.

- Medical management.
- Environmental evaluation
- Caregiver assessment
- Interaction and coordination with outside resources and practitioners and providers.
- Requirements for periodic review.
- When applicable, revision of the care plan

- Principal Care Management Services: CMS finalized the proposal to create this new service to recognize care management services for patients with only one chronic condition that would be provided by a physician or clinical staff under the direction of a physician or other qualified healthcare provider. There are no specialty restrictions on these new services, and they would be available to providers who are managing a patient's total care over a calendar month without any restrictions on a provider's specialty. A qualifying condition would typically be expected to last between three months and a year, or until the death of a patient, may have led to a recent hospitalization, and/or place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. The agency included a requirement in the final rule that ongoing communication and care coordination between all practitioners furnishing care to the beneficiary must be documented by the practitioner billing for PCM in the patient's medical record.

CMS adopted two new G-codes to describe these services: G2064 and G2065:

- G2064 describes at least 30 minutes of care in a calendar month provided by a physician or other qualified health care professional. This service is for a single high-risk disease and includes the following elements: One complex chronic condition lasting at least 3 months, which is the focus of the care plan, the condition is of sufficient severity to place patient at risk of hospitalization or have been the cause of a recent hospitalization, the condition requires development or revision of disease-specific care plan, the condition requires frequent adjustments in the medication regimen, and/or the management of the condition is unusually complex due to comorbidities.

- G2065 has the same time requirement over a calendar month and has the same requirements, but is delivered by clinical staff under the direction of a physician or other qualified health care professional.

CMS finalized 1.45 work RVU and 0.61 work RVU for G2064 and G2065 respectively. The agency did not finalize the proposal to create an add-on code for additional time spent each month (similar to the proposed GCCC2) when PCM services are furnished by clinical

staff under the direction of the billing practitioner. Since this is a new service, CMS believes it is more appropriate to monitor uptake and stakeholder response and consider establishing a separate add-on code in future rulemaking.

To bill a PCM service, CMS set out the elements of CCM that will be required in Table 24, transcribed from the final rule.

TABLE 24: Principal Care Management Services Summary

PCM Service Summary*
Verbal Consent • Inform regarding availability of the service; that only one practitioner can bill per month; the right to stop services effective at the end of any service period; and that cost sharing applies (if no supplemental insurance). • Document that consent was obtained.
Initiating Visit for New Patients (separately paid)
Certified Electronic Health Record (EHR) Use • Structured Recording of Core Patient Information Using EHR (demographics, problem list, medications, allergies).
24/7 Access ("On Call" Service)
Designated Care Team Member
Disease Specific Care Management Disease Specific Care Management may include, as applicable: • Systematic needs assessment (medical and psychosocial). • Ensure receipt of preventive services. • Medication reconciliation, management and oversight of self-management.
Disease Specific Electronic Care Plan • Plan is available timely within and outside the practice (can include fax). • Copy of care plan to patient/caregiver (format not prescribed). • Establish, implement, revise or monitor the plan.
Management of Care Transitions/Referrals (e.g., discharges, ED visit follow up, referrals, as applicable). • Create/exchange continuity of care document(s) timely (format not prescribed).
Home- and Community-Based Care Coordination • Coordinate with any home- and community-based clinical service providers, and document communication with them regarding psychosocial needs and functional deficits, as applicable.
Enhanced Communication Opportunities • Offer asynchronous non-face-to-face methods other than telephone, such as secure email.

*All elements that are medically reasonable and necessary must be furnished during the month, but all elements do not necessarily apply every month. Consent need only be obtained once, and initiating visits are only for new patients or patients not seen within a year prior to initiation of PCM.

CMS received public comments on how best to educate practitioners and beneficiaries on the benefit of PCM services, including requests for CMS to provide guidance on billing and coding criteria, clinical situations where PCM may be billed, and what defines a complex condition. The agency appreciated the feedback and will continue to engage with stakeholders as PCM services are implemented. Stakeholders are encouraged to continue to submit questions and information to CMS that may be considered in future rulemaking.

- Chronic Care Remote Physiologic Monitoring Services: The CPT Editorial Panel recently revised CPT code 99457 (Remote physiologic monitoring treatment, management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; initial 20 minutes). The panel also created the new add-on CPT code 99458 for an additional 20 minutes of care that month.

Based on stakeholder feedback in public comments, CMS will now accept the RUC-recommended value of 0.61 work RVU for new CPT code 99458, and finalized the RUC-recommended direct PE. CMS also finalized the proposal that these two RPM services may be furnished under general, rather than direct, supervision, the same supervision requirement for other designated care management services.

Reimbursement for Online Digital Evaluation Services (e-Visits) – Page 799

CMS finalized its proposal to pay six non-face-to-face codes to describe the care provided for patient-initiated digital communications that require a clinical decision that otherwise typically would have been provided in the office. These services are for established patients only and cover the cumulative time over a seven-day period required to deliver this care. Three of these codes can be billed by non-physician healthcare providers who cannot independently bill these services, and the other three are for physician services. Below find the descriptors and proposed work values of the three physician codes:

- 99421 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes*) – 0.25 work RVU
- 99422 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes*) – 0.50 work RVU
- 99423 (*Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes*) – 0.80 work RVU

Review and Verification of Medical Record Documentation – Page 377

Last year, CMS finalized a policy to allow a physician, resident, or nurse to document in the medical record that the teaching physician was present at the time the service was delivered. They also eliminated the requirement for the teaching physician to document the extent of his own participation in the review and direction of the services furnished to each beneficiary and instead to allow the resident or nurse to document the extent of the teaching physician's participation.

CMS finalized its proposal to provide the same relief for nonphysician practitioners authorized to deliver Part B services, including nurse practitioners (NPs), clinical nurse

specialists (CNSs), certified nurse midwives (CNMs) and physician assistants (PAs). Effective January 1, 2020 the furnishing practitioner will now be able to review and verify, rather than redocument, information included in the medical record by these students.

In response to comments, CMS expanded the proposal to include certified registered nurse anesthetists (CRNAs) and modified the proposal to explicitly list the types of eligible students including medical, PA, NP, CNS, CNM, and CRNA.

Potentially Misvalued Services – Page 165

CMS made one nomination and received three additional nominations for potentially misvalued codes, prior to the February 10, 2019 deadline. The Endocrine Society nominated two thyroid fine needle aspiration services: CPT code 10005 (Fine needle aspiration biopsy, including ultrasound guidance; first lesion) and CPT code 10021 (Fine needle aspiration biopsy, without imaging guidance; first lesion).

CMS decided not to include CPT codes 10005 and 10021 on the list of potentially misvalued services because in their assessment they did not receive any additional information to consider in the context of their previous review of the services.

Insertion, Removal, and Removal and Insertion of Implantable Interstitial Glucose Sensor System (Category III CPT codes 0446T, 0447T, and 0448T) – Page 180

The implantable interstitial glucose sensors are part of systems that can allow real-time glucose monitoring, provides glucose trend information, and signal alerts for detection and prediction of episodes of hypoglycemia and hyperglycemia. This family of Category III CPT codes is currently contractor priced and the agency learned the contractor pricing for these services has resulted in confusion about Medicare payment rules for these types of services and reduced access for Medicare beneficiaries.

CMS is seeking information from stakeholders to ensure proper payment for these services by establishing national payment rates in future rulemaking. The agency specifically requests information on the resources required to deliver these services, including the work RVUs, work time, and the direct PE inputs. Any recommendations received by February 10, 2020 will be considered in the CY 2021 PFS rulemaking.

STARK Advisory Opinion Process – Page 1194

CMS issues written advisory opinions on a case-by-case basis about whether a physician referral for certain health services is prohibited under Section 1877 of the Social Security

Act (the "Stark Law"). In 2018, CMS issued a Request for Information (RFI) to gather public input on how to address unnecessary burden created by the physician self-referral law, focusing in part, on how it may impede care coordination, a key aspect of value-based healthcare. In response to the RFI, many provider groups urged CMS to update the regulations governing its advisory opinion process on physician referrals to reduce provider burden and uncertainty around compliance with the Stark Law.

CMS finalized changes to its advisory opinion process to address these stakeholder comments. The agency may reject an advisory opinion request or not issue an advisory opinion if it does not describe the arrangement at issue with enough detail or the requestor does not respond to CMS' request for additional information in a timely manner.

The agency also finalized their proposal to amend §411.370(e)(2), which restricts CMS from issuing advisory opinions if another government agency is already issuing an opinion on a similar request. This change would give CMS more discretion to determine, after consulting with the Office of Inspector General (OIG) and the Department of Justice (DOJ) about whether acceptance of the advisory opinion request is appropriate.

The agency established a 60-day timeline for issuing advisory opinions, which would begin on the date that CMS formally accepts a request for an advisory opinion, and will provide requestors the option to request an expedited review.

CMS finalized their proposal to revise the language to clarify that the certification must be signed by an officer that is authorized to act on behalf of the requestor. CMS considered eliminating the certification requirement all together, since federal law already prohibits materially false statements in matters relating to federal agencies; however commenters responded that this requirement was "appropriate and not overly burdensome." CMS will continue to enforce the certification requirement.

The agency also will adopt an hourly fee of $220 for preparation of an advisory opinion, which reflects the costs incurred by the agency for the work. However, they stated that they will consider discounting the $220 rate on a case-by-case basis. This is particularly important for rural providers, in which costs must be affordable. In the proposed rule, CMS noted that they are considering adding a provision establishing an expedited pathway for requestors seeking an opinion within 30 days, for which they propose to charge $440 per hour to process. In the final rule, CMs decided to finalize an expedited review pathway, however they are not finalizing a $440 hourly rate.

The agency finalized several proposals to make advisory opinions more useful compliance tools for stakeholders. First, under Sec 411.387(a), an advisory opinion will be binding on the Secretary of HHS and a favorable advisory opinion will preclude the imposition of sanctions against the parties requesting the opinion, as well as any individuals or entities that are "parties to the specific arrangement with respect to which the advisory opinion is issued." The agency also finalized its proposal to recognize that individuals and entities may reasonably rely on an advisory opinion as non-binding guidance, which would be aligned with current practice.

Open Payments Program – Page 1110

The Open Payments program was established to increase transparency by providing information about financial relationships between the pharmaceutical and the medical device industries and health care providers. Specifically, the program requires manufacturers of covered drugs, devices, biologicals, or medical supplies to annually submit information for the preceding calendar year about certain payments or other transfers of value made to "covered recipients." Examples of payments or other transfers of value that must be reported include research, honoraria, gifts, travel expenses, meals, grants, and other compensation.

CMS finalized their proposal to expand the definition of a covered recipient, which currently includes physicians and teaching hospitals to be consistent with Section 6111 of the SUPPORT Act to also include "mid-level practitioners," including PAs, NPs, CNSs, CRNAs, and CNMs beginning January 1, 2022.

CMS also finalized their proposal to revise the "Nature of Payment" categories by consolidating two duplicative categories for continuing education programs to be listed as "medical education programs" and adding three new "Nature of Payment" categories: debt forgiveness, long-term medical supply or device loan, and acquisitions.

The agency is also finalizing their proposal to require manufactures and applicable group purchasing organizations (GPOs) to provide the device identifiers (DIs) in Open Payments reporting to enhance the usefulness of Open Payments data and provide more precise information about the medical supplies and devices associated with a transaction.

CMS' revisions will become effective for data collection beginning in CY 2021 and data reporting in CY 2022.

Physician Supervision for Physician Assistant (PA) Services – Page 365

Currently, the supervision requirement for PAs requires their services to be delivered under a physician's overall direction and control, but the physician's presence is not required

during the performance of these services. The CY 2018 PFS proposed rule included an RFI on CMS flexibilities and efficiencies and in response to this RFI, the agency received feedback about recent changes in the practice of medicine for PAs regarding physician supervision which has resulted in changes to scope of practice laws for PAs across state lines. CMS reported that stakeholders have suggested that the current regulatory definition of physician supervision as it applies to PAs could "inappropriately restrict the practice of PAs in delivering their professional services to the Medicare population."

In response to the CY 2020 Proposed Rule, commenters stated that deferring to state law and scope of practice rules for supervision of PA services will enable PAs to practice at the top of their education and expertise. This could then address underlying issues related to healthcare workforce needs in certain states, particularly those with access issues including rural and underserved areas. In contrast, other commenters stated that CMS should not revise the current PA supervision requirements.

Nevertheless, CMS is now finalizing their proposal to revise the physician supervision requirement for PA services under Medicare. Specifically, CMS is granting PAs the flexibility to practice in accordance with state law requirements rather than the current general supervision requirement. In the absence of a state law, the physician supervision requirement may be met by documentation in the medical record of the PA's approach to working with physicians in furnishing their services.

Quality Payment Program (QPP)/Merit-Based Incentive Payment System (MIPS) Provisions – Page 1228

A high-level summary of the proposed changes to the Quality Payment Program (QPP) follow. A more detailed summary will be provided separately.

MIPS Value Pathways initiative

CMS will outline the details of the MVP in next year's rulemaking cycle. In this final rule, CMS modified the proposed MVP framework, which will be defined by four guiding principles:

1) MVPs should consist of limited sets of measures and activities that are meaningful to clinicians, which will reduce or eliminate clinician burden related to selection of measures and activities, simplify scoring, and lead to sufficient comparative data;
2) MVPs should include measures that encourage performance improvement in high priority areas;
3) MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers when choosing care; and

4) MVPs should reduce barriers to APM participation by including measures that are part of APMs, and by linking cost and quality measurement.

CMS envisions that MVPs will be organized around clinician specialty or health condition and will encompass a set of related measures and activities. Grouping quality and cost measures and improvement activities that are highly correlated, along with the measures from the Promoting Interoperability performance category, will strengthen clinical improvement and streamline reporting.

The agency received over 2,100 comments related to the design and implementation of MVPs, which are not summarized in the final rule. The agency appreciated all of the feedback and will utilize the comments for future rulemaking on MVPs. CMS wants to engage with stakeholders as they develop the MVPs in the CY 2021 proposed rule, as well as additional ways to reduce burden in the MIPS program. For example, the agency is interested in recommendations to reduce burden across all four MIPS categories, as well as input on the number of measures included across categories, reporting timeframes, and data submission methods. CMS may hold public listening sessions and webinars as well as provide other opportunities for stakeholder engagement. CRD will monitor these opportunities and share ways to engage on this issue moving forward. The agency recognized stakeholder concerns about the timeline and remains committed to a smooth transition that does not immediately eliminate the MIPS framework. The agency also will not require MVP participation based on the comments they received.

<u>Key MIPS Provisions</u>

CMS finalized the proposed increase to the performance threshold to 45 points in 2020 and 60 points in 2021. The agency increased the additional performance threshold to 85 points for performance year 2022 and 2023.

MIPS Performance Category Measures and Scoring
Category Weights for the MIPS performance categories:

- The Quality performance category is weighted at 45 percent (no change from 2019).
    - CMS did not finalize the proposed change to decrease the quality performance category weight to 40 percent and will re-evaluate in future rulemaking.
- The Cost performance category is weighted at 15 percent (no change from 2019).
    - CMS did not finalize the proposed change to increase the cost performance category weight to 20 percent and will re-evaluate in future rulemaking.

- The Promoting Interoperability performance category is weighted at 25 percent (no change from 2019).
- The Improvement Activities performance category is weighted at 15 percent (no change from 2019).

Other MIPS Changes
Beginning with the 2021 performance period, CMS will strengthen the Qualified Clinical Data Registry (QCDR) measure standards for MIPS by requiring measure testing, harmonization, and clinician feedback to improve the quality of QCDR measures available for clinician reporting. QCDRs and Qualified Registries will still be required to provide timely performance feedback at least 4 times per year on all MIPS performance categories that the QCDR or Qualified Registry reports to CMS. Starting in 2021, this feedback must include information on how participants compare to other clinicians within the QCDR or Qualified Registry cohort who have submitted data on a given measure.

The agency finalized several changes to the measures for 2020. CMS added new specialty sets of measures for Audiology, Pulmonology and Endocrinology, among others. The agency finalized the removal of several standard-care and process measures, consistent with the Meaningful Measures Initiative. CMS also finalized the proposal to add ten new episode-based measures in the cost performance category to more accurately reflect the cost of care that specialists provide, and made changes to the interoperability measures that are discussed below.

Key Alternative Payment Model (APM) Provisions
The agency finalized the proposal to refine the APM scoring standard to improve flexibility for participants. Beginning in 2020, CMS will allow APM entities and MIPS eligible clinicians participating in APMS with the option to report a MIPS Quality measure for the MIPS Quality performance category. APM entities will receive a calculated score based on individual, TIN, or APM entity reporting based on the generally applicable MIPS reporting and scoring rules for the Quality performance category.

CMS will apply the existing uncontrollable circumstances policies to MIPS eligible clinicians participating in APMs, if they are subject to the APM scoring standard and would report on MIPS quality measures. The agency also clarified definitions and reporting requirements for APM participants.

MIPS Measures - Page 2071
Each year CMS makes changes to the MIPS measures set. The changes below apply to Endocrine Society members.

MIPS Quality Measures for 2022 MIPS Payment Year and Future Payment Years

- All-Cause Unplanned Admission for Patients with Multiple Chronic Diseases

Changes to Specialty Measure Sets for 2022 MIPS Payment Year and Future Payment Years (pg. 2081)

In addition to the considerations discussed in the introductory language for Table B, the specialty sets listed below take additional criteria into consideration, which includes, but is not limited to:

- Whether the measure reflects current clinical guidelines; and
- The coding of the measure includes relevant clinician types.

CMS may reassess the appropriateness of individual measures, on a case-by-case basis, to ensure appropriate inclusion in the specialty set.

Endocrinology---Finalized for Addition		
Measure Title and Description	**Measure Type/Domain**	**Measure Steward**
Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%): Percentage of patients 18-75 years of age with diabetes who had HbA1c > 9.0% during the measurement period.	Intermediate Outcome/Effective Clinical Care	NCQA
Screening for Osteoporosis for Women Aged 65-85 Years of Age: Percentage of female patients aged 65-85 years of age who ever had a central dual-energy X-ray absorptiometry (DXA) to check for osteoporosis.	Process/Effective Clinical Care	NCQA
Diabetes Eye Exam: Percentage of patients 18-75 years of age with diabetes and an active diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or diabetics with no diagnosis of retinopathy overlapping the measurement period who had a retinal or dilated eye exam by an eye care professional during the measurement period or in the 12 months prior to the measurement period.	Process/Effective Clinical Care	NCQA

Coronary Artery Disease (CAD): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy - Diabetes or Left Ventricular Systolic D: Percentage of patients aged 18 years and older with a diagnosis of coronary artery disease seen within a 12 month period who also have diabetes OR a current or prior Left Ventricular Ejection Fraction (LVEF) < 40% who were prescribed ACE inhibitor or ARB therapy.	Process/Effective Clinical Care	American Heart Association
Diabetes: Medical Attention for Nephropathy: The percentage of patients 18-75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.	Process/Effective Clinical Care	NCQA
Diabetes Mellitus: Diabetic Foot and Ankle Care, Peripheral Neuropathy—Neurological Examination: Percentage of patients aged 18 years and older with a diagnosis of diabetes mellitus who had a neurological examination of their lower extremities within 12 months	Process/Effective Clinical Care	American Podiatric Medical Association
Preventive Care and Screening—BMI Screening and Follow-up Plan: Percentage of patients aged 18 years and older with a BMI documented during the current encounter or during the previous twelve months AND with a BMI outside of normal parameters, a follow-up plan is documented during the encounter or during the previous twelve months of the current encounter. Normal Parameters: Age 18 years and older BMI ≥ 18.5 and < 25 kg/m2.	Process/Community + Population Health	CMS

Documentation of Current Medications in the Medical Record: Percentage of visits for patients aged 18 years and older for which the MIPS eligible clinician attests to documenting a list of current medications using all immediate resources available on the date of the encounter. This list must include ALL known prescriptions, over-thecounters, herbals, and vitamin/mineral/dietary (nutritional) supplements AND must contain the medications' name, dosage, frequency and route of administration.	Process/Patient Safety	CMS
Preventive Care and Screening: Screening for Depression and Follow-up Plan: Percentage of patients aged 12 years and older screened for depression on the date of the encounter using an age appropriate standardized depression screening tool AND if positive, a follow-up plan is documented on the date of the positive screen.	Process/Community + Population Health	CMS
Preventive Care and Screening: Tobacco Use: Screening and Cessation Intervention: Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco cessation intervention if identified as a tobacco user. Three rates are reported: a. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months b. Percentage of patients aged 18 years and older who were identified as a tobacco user who received tobacco cessation intervention c. Percentage of patients aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received tobacco	Process/Community + Population Health	PCPI

cessation intervention if identified as a tobacco user		
Controlling High Blood Pressure: Percentage of patients 18 - 85 years of age who had a diagnosis of hypertension overlapping the measurement period and whose most recent blood pressure was adequately controlled (< 140/90 mmHg) during the measurement period.	Intermediate Outcome/Effective Clinical Care	NCQA
Closing the Referral Loop: Receipt of Specialist Report: Percentage of patients with referrals, regardless of age, for which the referring provider receives a report from the provider to whom the patient was referred.	Process/Communication + Care Coordination	CMS

Osteoporosis Management in Women who Had a Fracture: The percentage of women age 50-85 who suffered a fracture in the six months prior to the performance period through June 30 of the performance period and who either had a bone mineral density test or received a prescription for a drug to treat osteoporosis in the six months after the fracture.	Process/Effective Clinical Care	NCQA
Statin Therapy for the Prevention and Treatment of Cardiovascular Disease: Percentage of the following patients - all considered at high risk of cardiovascular events - who were prescribed or were on statin therapy during the measurement period: • Adults aged ≥ 21 years who were previously diagnosed with or currently have an active diagnosis of clinical atherosclerotic cardiovascular disease (ASCVD); OR • Adults aged ≥21 years who have ever had a fasting or direct lowdensity lipoprotein cholesterol (LDL-C) level ≥ 190 mg/dL or were previously diagnosed with or currently have an	Process/Effective Clinical Care	CMS

active diagnosis of familial or pure hypercholesterolemia OR • Adults aged 40-75 years with a diagnosis of diabetes with a fasting or direct LDL-C level of 70-189 mg/dL.		
Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy: Patients determined as having prostate cancer who are currently starting or undergoing androgen deprivation therapy (ADT), for an anticipated period of 12 months or greater and who receive an initial bone density evaluation. The bone density evaluation must be prior to the start of ADT or within 3 months of the start of ADT.	Process/Effective Clinical Care	Oregon Urology Institute

APPENDIX A

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

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Allergy/Immunology	$237	0%	0%	0%	0%
Anesthesiology	$2,002	0%	0%	0%	0%
Audiologist	$71	0%	1%	0%	1%
Cardiac Surgery	$281	-1%	-1%	0%	-2%
Cardiology	$6,618	0%	0%	0%	0%
Chiropractor	$756	0%	0%	-1%	-1%
Clinical Psychologist	$793	1%	2%	0%	3%
Clinical Social Worker	$787	0%	3%	0%	4%
Colon And Rectal Surgery	$163	0%	1%	0%	1%
Critical Care	$349	0%	0%	0%	0%
Dermatology	$3,550	0%	1%	-1%	0%
Diagnostic Testing Facility	$703	0%	-3%	0%	-3%
Emergency Medicine	$3,035	1%	0%	1%	1%
Endocrinology	$490	0%	0%	0%	0%
Family Practice	$6,056	0%	0%	0%	0%
Gastroenterology	$1,721	0%	0%	-1%	0%
General Practice	$410	0%	0%	0%	0%
General Surgery	$2,047	0%	0%	0%	0%
Geriatrics	$188	0%	0%	0%	0%
Hand Surgery	$226	0%	1%	0%	1%
Hematology/Oncology	$1,678	0%	0%	0%	0%
Independent Laboratory	$597	0%	1%	0%	1%
Infectious Disease	$643	0%	0%	0%	0%
Internal Medicine	$10,581	0%	0%	0%	0%
Interventional Pain Mgmt	$890	0%	1%	0%	1%
Interventional Radiology	$434	0%	-2%	0%	-1%
Multispecialty Clinic/Other Phys	$149	0%	0%	0%	0%
Nephrology	$2,176	0%	0%	0%	0%
Neurology	$1,512	-1%	-1%	0%	-2%
Neurosurgery	$807	0%	0%	-1%	0%
Nuclear Medicine	$50	0%	1%	0%	1%
Nurse Anes / Anes Asst	$1,297	0%	0%	0%	0%
Nurse Practitioner	$4,532	0%	0%	0%	0%
Obstetrics/Gynecology	$624	0%	1%	0%	1%
Ophthalmology	$5,413	-2%	-2%	0%	-4%
Optometry	$1,335	0%	-1%	0%	-2%
Oral/Maxillofacial Surgery	$72	0%	0%	-1%	-1%
Orthopedic Surgery	$3,750	0%	1%	0%	1%
Other	$35	0%	0%	0%	0%
Otolaryngology	$1,230	0%	0%	0%	0%
Pathology	$1,212	0%	0%	0%	0%
Pediatrics	$64	0%	0%	0%	0%
Physical Medicine	$1,117	0%	0%	0%	1%
Physical/Occupational Therapy	$4,273	0%	0%	0%	0%
Physician Assistant	$2,650	0%	0%	0%	0%
Plastic Surgery	$373	0%	0%	0%	0%
Podiatry	$2,017	0%	1%	0%	2%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Portable X-Ray Supplier	$96	0%	0%	0%	0%
Psychiatry	$1,134	0%	1%	0%	1%
Pulmonary Disease	$1,665	0%	0%	0%	0%
Radiation Oncology And Radiation Therapy Centers	$1,762	0%	0%	0%	0%
Radiology	$4,995	0%	0%	0%	0%
Rheumatology	$536	0%	0%	0%	0%
Thoracic Surgery	$355	-1%	0%	0%	-1%
Urology	$1,745	0%	1%	0%	1%
Vascular Surgery	$1,211	0%	-2%	0%	-2%
TOTAL	**$93,487**	**0%**	**0%**	**0%**	**0%**

* Column F may not equal the sum of columns C, D, and E due to rounding.

APPENDIX B

TABLE 120: Estimated Specialty Level Impacts of Finalized E/M Payment and Coding Policies

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact*
Allergy/Immunology	$236	4%	3%	0%	7%
Anesthesiology	$1,993	-5%	-1%	0%	-7%
Audiologist	$70	-4%	-2%	0%	-6%
Cardiac Surgery	$279	-5%	-2%	-1%	-8%
Cardiology	$6,595	2%	1%	0%	3%
Chiropractor	$750	-5%	-3%	-1%	-9%
Clinical Psychologist	$787	-7%	0%	0%	-7%
Clinical Social Worker	$781	-7%	0%	0%	-6%
Colon And Rectal Surgery	$162	-3%	-1%	-1%	-4%
Critical Care	$346	-5%	-1%	0%	-6%
Dermatology	$3,541	0%	1%	-1%	-1%
Diagnostic Testing Facility	$697	-1%	-4%	0%	-4%
Emergency Medicine	$3,021	-6%	-2%	1%	-7%
Endocrinology	$488	11%	5%	1%	16%
Family Practice	$6,019	8%	4%	1%	12%
Gastroenterology	$1,713	-2%	-1%	-1%	-4%
General Practice	$405	5%	2%	0%	8%
General Surgery	$2,031	-3%	-1%	0%	-4%
Geriatrics	$187	2%	1%	0%	3%
Hand Surgery	$226	-1%	0%	0%	-1%
Hematology/Oncology	$1,673	8%	4%	1%	12%
Independent Laboratory	$592	-3%	-1%	0%	-4%
Infectious Disease	$640	-3%	-1%	0%	-3%
Internal Medicine	$10,507	2%	2%	0%	4%
Interventional Pain Mgmt	$885	4%	3%	1%	8%
Interventional Radiology	$432	-3%	-3%	0%	-6%
Multispecialty Clinic/Other Phys	$148	-2%	0%	0%	-2%
Nephrology	$2,164	-2%	0%	0%	-2%
Neurology	$1,503	2%	5%	0%	8%
Neurosurgery	$802	-3%	-1%	-2%	-6%
Nuclear Medicine	$50	-4%	0%	0%	-5%
Nurse Anes / Anes Asst	$1,291	-7%	-2%	0%	-9%
Nurse Practitioner	$4,503	5%	3%	0%	8%
Obstetrics/Gynecology	$620	4%	3%	0%	7%
Ophthalmology	$5,398	-4%	-5%	0%	-10%
Optometry	$1,325	-2%	-3%	0%	-5%
Oral/Maxillofacial Surgery	$71	-1%	-1%	-1%	-4%
Orthopedic Surgery	$3,734	-1%	0%	0%	-2%
Other	$34	-3%	-2%	0%	-5%
Otolaryngology	$1,225	3%	2%	0%	5%
Pathology	$1,203	-5%	-3%	-1%	-8%
Pediatrics	$62	3%	2%	0%	6%
Physical Medicine	$1,110	-2%	0%	0%	-2%
Physical/Occupational Therapy	$4,248	-4%	-3%	0%	-8%
Physician Assistant	$2,637	4%	2%	0%	7%
Plastic Surgery	$369	-3%	-1%	-1%	-5%
Podiatry	$1,998	0%	1%	0%	1%

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact*
Portable X-Ray Supplier	$94	-1%	-3%	0%	-4%
Psychiatry	$1,120	4%	3%	0%	7%
Pulmonary Disease	$1,658	0%	1%	0%	1%
Radiation Oncology And Radiation Therapy Centers	$1,756	-2%	-2%	0%	-4%
Radiology	$4,971	-5%	-3%	0%	-8%
Rheumatology	$534	9%	5%	1%	15%
Thoracic Surgery	$352	-5%	-2%	-1%	-7%
Urology	$1,739	4%	4%	0%	8%
Vascular Surgery	$1,203	-2%	-3%	0%	-5%
TOTAL	**$92,979**	**0%**	**0%**	**0%**	**0%**

** Column F May Not Equal The Sum Of Columns C, D, And E Due To Rounding.*