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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 Calendar Year (CY) 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 all CPT Codes, can be found here. The rule's provisions will be effective January 1, 2020 unless stated otherwise.

Conversion Factor and Specialty Impact

The conversion factor for 2020 is $36.0896, an increase of only 5 cents from 2019. Table 119, extracted from the rule and attached to this summary, shows 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. For 2019, the impact on Hematology/Oncology is 0%.

Attached to this summary is a chart (Appendix A) showing the proposed changes in relative values (RVUs) and payment rates in 2020 for services provided by hematologists/oncologists. In general, the values for these services in 2020 remain stable, with little fluctuation.

Payment for Evaluation and Management Visits – Changes Effective January 1, 2021

For CY 2021, CMS is proposing significant improvements to the documentation and payment of outpatient evaluation and management (E/M) services. Last year, the agency had created a single, blended payment rate for level 2 through 4 visits with simplified documentation requirements. In this rule, CMS decided not to move forward on its previous proposal and is implementing the revised the E/M code definitions and document requirements developed by the AMA CPT Editorial Panel as proposed in 2020 MPFS Proposed Rule. ASH is supportive of this revised policy.

CMS estimates the specialty level impact of these E/M changes if implemented without change in CY 2021 in Table 120 in the rule, which is attached to this summary. According to CMS, the impact of the E/M revisions in 2021 will result in a 12% increase for hematology/oncology. A detailed description of the E/M policies proposed 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 the new prolonged add-on code. These values are based on a survey of over 50 specialty societies. CMS believes these values more accurately account for the time and intensity of E/M services but will consider how to minimize the negative redistribution 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*
*** Payment based on the proposed 2021 relative value units and the CY 2019 Conversion Factor rates.*

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

Prolonged Service: CMS will pay separately for prolonged outpatient E/M services using the new CPT add-on code 99XXX (a new code number will be assigned in 2020) and will delete HCPCS code 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 code may 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. ASH is supportive of the creation of prolonged service ad-on codes and believes this will especially be useful for hematologists, who treat complex and rare diseases. ASH believes there is clear value for the implementation of the prolonged service add-on for providers who choose to document their E/M visits by time.

Complexity Add-on Code: CMS finalized its proposal to establish a single add-on code with a revised descriptor to 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 the new add-on code (GPC1X) is 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. The code may be billed with any level outpatient E/M service. ASH is supportive of the revision of the complexity add-on code because it is tied to the patient's condition rather than certain types of specialty care; and, will ensure that the outpatient E/M services accurately reflect the cognitive work provided.

Global Surgical Packages: CMS finalized its policy to reject the RUC's recommendation to apply the outpatient E/M visit RVU increases to the 10- and 90-day global surgical services. CMS decided it did not want to make any changes to the global period RVUs until it had accurate information about required resources, including work, practice expense, and malpractice and post-operative services.

Care Management Services – Changes Effective CY 2020

Besides addressing the outpatient E/M code valuations and documentation requirements, CMS separately addressed care management services, which are 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

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 month. Currently, there are two subsets of codes: one for non-complex chronic care management and one for complex chronic care management.

Non-Complex CCM Services by Clinical Staff (CPT code 99490, HCPCS code G2058)
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 is finalizing its proposal to create a new HCPCS code, G2058, to describe each additional 20 minutes of service as reported by clinical staff a maximum of two times in a given service period per month. The new G-code is valued at 0.54 work RVUs.

Complex CCM Services (CPT codes 99487 and 99489)
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 new HCPCS codes for complex CCM services. The agency will continue to recognize CPT codes 99487 and 99489 but 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 its 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 full list of the typical care plan requirements can be found on pg. 62692 of the final rule.

Principal Care Management Services: CMS finalized its proposal to create a new service provided by a physician or clinical staff under the direction of a physician or other qualified healthcare provider to recognize care management services for patients with only one chronic condition. 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. A qualifying condition typically would 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 the

practitioner billing the PCM code document ongoing communication and care coordination between all practitioners furnishing care to the beneficiary in the patient's medical record.

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

- G2064 (1.45 RVUs) 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 or for one complex chronic condition lasting at least 3 months, which is the focus of the care plan. In addition, the condition is of sufficient severity to place patient at risk of hospitalization or has 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 (0.61 RVUs) has the same time requirement over a calendar month and other requirements as G2064, but is delivered by clinical staff under the direction of a physician or other qualified health care professional.

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

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. CMS accepted 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.

Reimbursement for Online Digital Evaluation Services (e-Visits)

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. ASH appreciates that CMS is acknowledging the non-face-to-face work that is done routinely by physicians. These services are for established patients only and cover the cumulative time over a seven-day period required to deliver this care. Non-physician healthcare providers, who cannot independently bill these services, can report three of the codes 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

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 a service was delivered. They also eliminated the requirement for the teaching physician to document the extent of his or her 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 non-physician 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 re-document, information included in the medical record by these students.

Open Payments Program

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 annually to 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 its 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 include "mid-level practitioners," including PAs, NPs, CNSs, CRNAs, and CNMs beginning January 1, 2022.

CMS also finalized its proposal to revise the "Nature of Payment" categories that must be reported 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 its proposal to require manufactures and applicable group purchasing organizations (GPOs) to provide the device identifiers (DIs) in Open Payments reporting.

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

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 their services. CMS is finalizing its 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.

Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs

Section 2005 of the Substance Use Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act established a new Medicare Part B benefit for opioid use disorder (OUD). To meet the statutory requirements, CMS has finalized the following regulatory provisions:

Revised definitions of Opioid Use Disorder (OUD) treatment services: CMS finalized its definition of OUD treatment services to include five statutorily-required items and services in the definition: (1) opioid agonist and antagonist treatment medications approved by the FDA for treatment of OUD; (2) dispensing and administration of such medications; (3) substance use counseling; (4) individual and group therapy; and (5) toxicology testing.

Medicare enrollment policies for Opioid Treatment Programs (OTPs): CMS finalized its proposed to adopt the existing Substance Abuse and Mental Health Services Administration (SAMHSA) requirements for certification and accreditation as the health and safety standards that must be met in order for an OTP to participate in Medicare. Additional enrollment policies are outlined in the "Medicare Enrollment of Opioid Treatment Programs and Enhancements to Existing General Enrollment Policies Related to Improper Prescribing and Patient Harm" section of the final rule.

Bundled payments and add-on services for the treatment of OUD:

- CMS finalized its proposal to calculate the bundled payment rate for services furnished by OTPs by combining the drug component and the non-drug components. Additionally, the agency is finalizing its proposal on bundled payment rates to be based, in part, on the type of medication used for treatment. The following bundled categories reflect the medications currently approved by the FDA under section 505 of the United

States Federal Food, Drug, and Cosmetic Act (FFDCA) for use in treatment of OUD: methadone (oral), buprenorphine (oral), buprenorphine (injection), buprenorphine (implant), naltrexone (injection).

- In addition, CMS finalized its proposal to allow OTPs to bill for an episode of care using the medication not otherwise specified (NOS) code (HCPCS code G2075) when an OTP furnishes medication assisted treatment (MAT) using a new FDA-approved opioid agonist or antagonist medication for OUD treatment that is not specified in one of the existing approved codes.
- CMS finalized the proposal to create an add-on code to describe an adjustment to bundled payment when counseling or therapy services are furnished.
    - HCPCS code G2080: *Each additional 30 minutes of counseling or group or individual therapy in a week of medication assisted treatment, (provision of the services by a Medicare-enrolled Opioid Treatment Program); List separately in addition to code for primary procedure.*

Telehealth services for the treatment of OUD: CMS finalized its proposal to allow OTPs to use two-way interactive audio-video communication technology, as clinically appropriate, in furnishing substance use counseling and individual and group therapy services.

Coverage for medication assisted treatment (MAT): Historically, there has been a gap in Medicare coverage of MAT for OUD because methadone has not been covered. There are three drugs currently approved by the FDA for the treatment of opioid dependence: buprenorphine, methadone, and naltrexone. In finalizing the bundled payment proposal, CMS is including coverage of the oral form of methadone.

Bundled Payments under the PFS for Substance Use Disorders

CMS believes that bundled payments "create incentives to provide efficient care by mitigating incentives tied to volume of services furnished." CMS established bundled payments for the overall treatment of OUD, which would include payment for management, care coordination, psychotherapy, and counseling activities. CMS states that the following services will not be included in the bundled payment: (1) payment for drugs involved in medication assisted treatment (MAT) and (2) payment for medically necessary toxicology testing.

CMS finalized its proposal to create three new G-codes. HCPCS code G2086 will describe the initial month of treatment, which includes initial assessments and development of a treatment plan; HCPCS code G2087 describes subsequent months of treatment; and HCPCS code G2088 describes additional counseling. CMS also finalized its proposal to allow OTPs to furnish psychotherapy, group psychotherapy, and substance use counseling as Medicare telehealth services using telecommunication as clinically appropriate.

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

A high-level summary of the proposed changes to the Quality Payment Program (QPP) follows.

MIPS Value Pathways (MVP) Initiative:

In this final rule, CMS modified the proposed MVP framework, which is 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 Alternative Payment Model (APM) participation by including measures that are part of APM's 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.

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.

Key MIPS Provisions

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).
- The Cost performance category is weighted at 15 percent (no change from 2019).
- 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.

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

Each year CMS makes changes to the MIPS measures set. The changes below apply to ASH 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

Oncology/Hematology—Finalized for Addition		
Measure Title and Description	**Measure Type/Domain**	**Measure Steward**
Hematology: MDS and Acute Leukemia: Baseline Cytogenetic Testing Performed in Bone Marrow	Process/Effective Clinical Care	ASH
Hematology: Multiple Myeloma Treatment with Bisphosphonates	Process/Effective Clinical Care	ASH
Hematology: CLL: Baseline Flow Cytometry	Process/Effective Clinical Care	PCPI

Oncology/Hematology—Finalized for Removal		
Measure Title and Description	**Measure Type/Domain**	**Measure Steward**
HER2 Negative or Undocumented Breast Cancer Patients Spared Treatment with HER2-Targeted Therapies	Process/Efficiency and Cost Reduction	ASCO
Percentage of Patients who Died from Cancer with More than One Emergency Department Visit in the Last 30 Days of Life (lower score – better)	Outcome/Effective Clinical Care	ASCO
Percentage of Patients who Died from Cancer Not Admitted to Hospice (lower score---better)	Process/Effective Clinical Care	ASCO
Zoster (Shingles) Vaccination	Process/Community + Population Health	PPRNet

APPENDIX A

2020 Final Physician Fee Schedule (CMS-1715-F)									
Payment Rates for Medicare Physician Services - Hematology/Oncology									
CPT Code	Descriptor	NON-FACILITY (OFFICE)				FACILITY (HOSPITAL)			
		2020		2019	% payment change 2019 to 2020	2020		2019	% payment change 2019 to 2020
		RVUs	Payment CF=$36.0896	Payment CF = $36.0391		RVUs	Payment CF=$36.0896	Payment CF = $36.0391	
20939	Bone marrow aspir bone grfg	NA	NA	NA	NA	2.03	$73.26	$69.20	5.9%
36430	Blood transfusion service	0.99	$35.73	$35.68	0.1%	NA	NA	NA	NA
36511	Apheresis wbc	NA	NA	NA	NA	3.15	$113.68	$111.72	1.8%
36512	Apheresis rbc	NA	NA	NA	NA	3.12	$112.60	$112.08	0.5%
36513	Apheresis platelets	NA	NA	NA	NA	3.15	$113.68	$113.88	-0.2%
36514	Apheresis plasma	19.17	$689.67	$738.80	-6.6%	2.75	$99.25	$99.47	-0.2%
36516	Apheresis, selective	55.44	$1,839.49	$2,027.92	-9.3%	2.44	$88.06	$88.66	-0.7%
36522	Photopheresis	54.60	$1,962.55	$2,206.31	-11.0%	2.82	$101.77	$100.55	1.2%
38205	Harvest allogenic stem cells	NA	NA	NA	NA	2.44	$88.06	$85.77	2.7%
38206	Harvest auto stem cells	NA	NA	NA	NA	2.43	$87.70	$86.13	1.8%
38220	Bone marrow aspiration	4.77	$172.51	$169.74	1.6%	2.01	$72.54	$71.72	1.1%
38221	Bone marrow biopsy	4.47	$160.96	$158.21	1.7%	2.00	$72.18	$72.08	0.1%
38222	Dx bone marrow bx & aspir	4.94	$177.92	$175.51	1.4%	2.24	$80.84	$80.73	0.1%
38230	Bone marrow collection	NA	NA	NA	NA	5.92	$213.65	$215.15	-0.7%
38232	Bone marrow harvest autolog	NA	NA	NA	NA	5.76	$207.88	$207.22	0.3%
38240	Bone marrow/stem transplant	NA	NA	NA	NA	6.78	$244.69	$235.34	4.0%
38241	Bone marrow/stem transplant	NA	NA	NA	NA	5.02	$181.17	$175.87	3.0%
38242	Lymphocyte infuse transplant	NA	NA	NA	NA	3.63	$131.01	$124.33	5.4%
88184	Flowcytometry/ tc, 1 marker	1.89	$67.85	$67.75	0.1%	NA	NA	NA	NA
88185	Flowcytometry/ tc, add-on	0.62	$22.38	$24.87	-10.0%	NA	NA	NA	NA
88187	Flowcytometry/read, 2-8	1.09	$38.98	$38.92	0.1%	1.09	$39.34	$38.92	1.1%
88188	Flowcytometry/read, 9-15	1.83	$66.40	$65.95	0.7%	1.83	$66.04	$65.95	0.1%
88189	Flowcytometry/read, 16 & <	2.46	$88.06	$88.30	-0.3%	2.46	$88.78	$88.30	0.5%
96360	Hydration iv infusion, init	0.96	$34.65	$38.56	-10.2%	NA	NA	NA	NA
96361	Hydrate iv infusion, add- on	0.38	$13.71	$13.69	0.1%	NA	NA	NA	NA
96365	Ther/ proph/ diag iv inf, init	2.00	$71.46	$72.80	-1.8%	NA	NA	NA	NA
96366	Ther/ proph/ dg iv inf, add- on	0.61	$22.01	$21.98	0.1%	NA	NA	NA	NA
96367	Tx/ proph/ dg addl seq iv inf	0.87	$31.40	$31.71	-1.0%	NA	NA	NA	NA
96368	Ther/ diag concurrent inf	0.59	$21.29	$21.26	0.1%	NA	NA	NA	NA
96372	Ther/ proph/ diag inj, sc/ im	0.40	$14.44	$16.94	-14.8%	NA	NA	NA	NA
96373	Ther/ proph/ diag inj, ia	0.52	$18.77	$19.10	-1.7%	NA	NA	NA	NA
96374	Ther/ proph/ diag inj, iv push	1.11	$40.06	$39.64	1.1%	NA	NA	NA	NA
96375	Ther/ proph/ diag inj add- on	0.46	$16.60	$16.94	-2.0%	NA	NA	NA	NA
96377	Applicaton on-body injector	0.56	$20.21	$20.54	-1.6%	NA	NA	NA	NA
96401	Chemotherapy, sc/im	2.22	$79.76	$80.73	-1.2%	NA	NA	NA	NA
96402	Chemo hormon antineopl sq/ im	0.89	$31.76	$31.35	1.3%	NA	NA	NA	NA
96405	Intralesional chemo admin	2.35	$84.81	$83.25	1.9%	0.84	$30.32	$30.27	0.1%
96406	Intralesional chemo admin	3.61	$129.56	$124.70	3.9%	1.31	$47.28	$47.21	0.1%
96409	Chemo, iv push, sngl drug	3.05	$109.35	$109.92	-0.5%	NA	NA	NA	NA
96411	Chemo, iv push, addl drug	1.66	$59.19	$59.46	-0.5%	NA	NA	NA	NA
96413	Chemo, iv infusion, 1 hr	3.95	$141.47	$143.08	-1.1%	NA	NA	NA	NA
96415	Chemo, iv infusion, addl hr	0.85	$30.68	$30.99	-1.0%	NA	NA	NA	NA
96416	Chemo prolong infuse w/ pump	3.95	$141.47	$143.44	-1.4%	NA	NA	NA	NA
96417	Chemo iv infus each addl seq	1.92	$68.57	$69.20	-0.9%	NA	NA	NA	NA
96420	Chemotherapy, push technique	2.93	$104.66	$106.32	-1.6%	NA	NA	NA	NA
96422	Chemotherapy,infusion method	4.81	$172.51	$174.79	-1.3%	NA	NA	NA	NA
96423	Chemo, infuse method add-on	2.23	$80.12	$80.73	-0.8%	NA	NA	NA	NA
96425	Chemotherapy,infusion method	5.10	$184.42	$185.24	-0.4%	NA	NA	NA	NA
96440	Chemotherapy, intracavitary	25.24	$908.74	$853.77	6.4%	3.57	$128.84	$128.66	0.1%
96446	Chemotx admn prtl cavity	5.68	$204.63	$208.31	-1.8%	0.73	$26.35	$28.47	-7.5%
96450	Chemotherapy, into CNS	5.08	$183.34	$184.88	-0.8%	2.26	$81.56	$81.81	-0.3%
96521	Port pump refill & main	4.13	$147.97	$148.84	-0.6%	NA	NA	NA	NA
96522	Refill/ maint pump/ resvr syst	3.45	$123.07	$121.81	1.0%	NA	NA	NA	NA
96523	Irrig drug delivery device	0.78	$27.79	$27.75	0.1%	NA	NA	NA	NA
96542	Chemotherapy injection	3.72	$132.45	$135.87	-2.5%	1.21	$43.67	$42.89	1.8%
G2010	Remot image submit by pt	0.34	$12.27	$12.61	-2.7%	0.26	$9.38	$9.37	0.1%
G2012	Brief check in by md/qhp	0.41	$14.80	$14.78	0.1%	0.37	$13.35	$13.33	0.1%

2020 Final Physician Fee Schedule (CMS-1715-F)									
Payment Rates for Medicare Physician Services - Evaluation and Management									
CPT Code	Descriptor	NON-FACILITY (OFFICE)				FACILITY (HOSPITAL)			
		2020		2019	% payment change 2019 to 2020	2020		2019	% payment change 2019 to 2020
		RVUs	Payment CF=$36.0896	Payment CF=$36.0391		RVUs	Payment CF=$36.0896	Payment CF=$36.0391	
99201	Office/outpatient visit new	1.29	$46.56	$46.49	0.1%	0.75	$27.07	$27.39	-1.2%
99202	Office/outpatient visit new	2.14	$77.23	$77.48	-0.3%	1.43	$51.61	$51.54	0.1%
99203	Office/outpatient visit new	3.03	$109.35	$109.92	-0.5%	2.14	$77.23	$77.48	-0.3%
99204	Office/outpatient visit new	4.63	$167.09	$166.86	0.1%	3.66	$132.09	$131.18	0.7%
99205	Office/outpatient visit new	5.85	$211.12	$209.75	0.7%	4.78	$172.51	$171.19	0.8%
99211	Office/outpatient visit est	0.65	$23.46	$23.07	1.7%	0.26	$9.38	$9.37	0.1%
99212	Office/outpatient visit est	1.28	$46.19	$45.77	0.9%	0.73	$26.35	$25.95	1.5%
99213	Office/outpatient visit est	2.11	$76.15	$75.32	1.1%	1.45	$52.33	$51.90	0.8%
99214	Office/outpatient visit est	3.06	$110.43	$110.28	0.1%	2.23	$80.48	$80.01	0.6%
99215	Office/outpatient visit est	4.11	$148.33	$147.76	0.4%	3.15	$113.68	$112.80	0.8%
99221	Initial hospital care	NA	NA	NA	NA	2.88	$103.94	$103.07	0.8%
99222	Initial hospital care	NA	NA	NA	NA	3.89	$140.39	$139.11	0.9%
99223	Initial hospital care	NA	NA	NA	NA	5.71	$206.07	$205.42	0.3%
99231	Subsequent hospital care	NA	NA	NA	NA	1.11	$40.06	$40.00	0.1%
99232	Subsequent hospital care	NA	NA	NA	NA	2.04	$73.62	$73.88	-0.3%
99233	Subsequent hospital care	NA	NA	NA	NA	2.94	$106.10	$105.59	0.5%
99291	Critical care first hour	7.89	$284.75	$281.83	1.0%	6.28	$226.64	$226.33	0.1%
99292	Critical care addl 30 min	3.49	$125.95	$124.70	1.0%	3.16	$114.04	$113.52	0.5%
99421	Ol dig e/m svc 5-10 min	0.43	$15.52	NA	NA	0.37	$13.35	NA	NA
99422	Ol dig e/m svc 11-20 min	0.86	$31.04	NA	NA	0.76	$27.43	NA	NA
99423	Ol dig e/m svc 21+ min	1.39	$50.16	NA	NA	1.21	$43.67	NA	NA
99446	Interprof phone/online 5-10	0.51	$18.41	NA	NA	0.51	$18.41	$18.38	0.1%
99447	Interprof phone/online 11-20	1.03	$37.17	NA	NA	1.03	$37.17	$36.40	2.1%
99448	Interprof phone/online 21-30	1.54	$55.58	NA	NA	1.54	$55.58	$54.78	1.5%
99449	Interprof phone/online 31/>	2.05	$73.98	NA	NA	2.05	$73.98	$72.80	1.6%
99451	Ntrprof ph1/ntrnet/ehr 5/>	1.04	$37.53	$37.48	0.1%	1.04	$37.53	$37.48	0.1%
99452	Ntrprof ph1/ntrnet/ehr rfrl	1.04	$37.53	$37.48	0.1%	1.04	$37.53	$37.48	0.1%
99453	Rem mntr physiol param setup	0.52	$18.77	$19.46	-3.6%	NA	NA	NA	NA
99454	Rem mntr physiol param dev	1.73	$62.44	$64.15	-2.7%	NA	NA	NA	NA
99457	Rem physiol mntr 20 min mo	1.43	$51.61	$51.54	0.1%	0.91	$32.84	$32.44	1.3%
99458	Rem physiol mntr ea addl 20	1.17	$42.22	NA	NA	0.91	$32.84	NA	NA
99471	Ped critical care initial	NA	NA	NA	NA	22.49	$811.66	$811.24	0.1%
99472	Ped critical care subsq	NA	NA	NA	NA	11.37	$410.34	$415.53	-1.2%
99487	Cmplx chron care w/o pt vsit	2.56	$92.39	$92.98	-0.6%	1.48	$53.41	$52.98	0.8%
99489	Cmplx chron care addl 30 min	1.24	$44.75	$46.49	-3.7%	0.73	$26.35	$26.67	-1.2%
99490	Chron care mgmt srvc 20 min	1.17	$42.22	$42.17	0.1%	0.91	$32.84	$32.44	1.3%
99491	Chrnc care mgmt svc 30 min	2.33	$84.09	$83.97	0.1%	2.33	$84.09	$83.97	0.1%
99495	Trans care mgmt 14 day disch	5.20	$187.67	$166.50	12.7%	3.48	$125.59	$112.08	12.1%
99496	Trans care mgmt 7 day disch	6.87	$247.94	$234.97	5.5%	4.59	$165.65	$162.54	1.9%
G0396	Alcohol/subs interv 15-30mn	1.02	$36.81	$36.40	1.1%	0.94	$33.92	$33.88	0.1%
G0397	Alcohol/subs interv >30 min	1.91	$68.93	$68.11	1.2%	1.83	$66.04	$65.95	0.1%
G0506	Comp asses care plan ccm svc	1.76	$63.52	$63.43	0.1%	1.29	$46.56	$46.49	0.1%
GCCC1	CCM first 20m	NOT FINALIZED	NOT FINALIZED	NA	NA	NOT FINALIZED	NOT FINALIZED	NA	NA
GCCC3	CCM multi cond 60 min	NOT FINALIZED	NOT FINALIZED	NA	NA	NOT FINALIZED	NOT FINALIZED	NA	NA
GCCC4	CCM add 30 min	NOT FINALIZED	NOT FINALIZED	NA	NA	NOT FINALIZED	NOT FINALIZED	NA	NA
G2058	CCM add 20min	1.05	$37.89	NA	NA	0.79	$28.51	NA	NA
G2064	Md mang high risk dx 30	2.55	$92.03	NA	NA	2.18	$78.68	NA	NA
G2065	Clin mang h risk dx 30	1.1	$39.70	NA	NA	1.1	$39.70	NA	NA

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.

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.*