November 1, 2020 – Today, the Centers or Medicare & Medicaid Services (CMS) released the final CY 2020 rule updating payment rates and other policies under the Medicare Physician Fee Schedule (PFS) and Quality Payment Program, effective January 1, 2020. The PFS Rule includes updates to payment rates and other policies under the Medicare Physician Fee Schedule (PFS) for CY 2020, quality reporting, ambulance, opioid treatment, Medicare Shared Savings program, open payments, Stark advisory opinions, and other provisions. Limited comments are due by 5:00 p.m. (ET) on December 31, 2019. AdvaMed will provide a detailed summary of the final rule soon. Highlights and links to the final rule and related materials are below.

After applying all adjustments, and the budget neutrality adjustment to account for changes in RVUs as required by law, the 2020 final PFS conversion factor (CF) is $36.09 (a slight increase over the 2019 PFS CF of $36.04). P. 1180-1184

Radiation Therapy Codes— Radiation Therapy Codes (HCPCS Codes G6001, G6002, G6003, G6004, G6005, G6006, G6007, G6008, G6009, G6010, G6011, G6012, G6013, G6014, G6015, G6016 and G6017)—For CY 2020, in the interest of payment stability, CMS will continue using the 2018 freeze rate G-codes, as well as their current work RVUs and direct PE inputs. CMS did not comment on extending the freeze thru the duration of the RO-APM. PGS. 806-808

NPWT— CMS is finalizing the work RVUs and direct PE inputs for NPWT as proposed for CY 2020. PGS. 794-798

Remote Interrogation Device Evaluation—CMS will use contractor priced G code and does not comment on developing another approach for developing valuation of technical portion of the CPT code in the future. PGS 728-734

Medicare telehealth services— For CY 2020, CMS finalized the addition of several codes to the list of telehealth services GYYY1, GYYY2, GYYY3 (G2086, G2087, and G2088) which describe bundled care episodes for opioid use disorders. PGS. 185-189
Opioid Use Disorder (OUD) Toxicology Testing—In light of comments regarding presumpti
definitive tests, CMS will build the payment for both types of tests into weekly bundled rates. CMS will
consider additional changes to payments for these tests in future rulemaking if they determine that
Medicare beneficiaries are experiencing access issues. PGS. 255-256

Bundled Payments—CMS will consider the many comments received, on ways to utilize bundled
payment to improve efficiency of health service delivery under PFS, in future rulemaking. PGS. 854-856

Open Payments—The rule finalizes policies to address the transparency of payments between
the pharmaceutical and medical device industry and certain types of health care providers and to make
the information available to the public. CMS finalized several provisions, effective for data collected
beginning in CY 2021 and reported in CY 2022, including: (1) expanding the definition of a covered
recipient to include the categories specified in the SUPPORT Act; (2) expanding the nature of payment
categories; and (3) standardizing data on reported covered drugs, devices, biologicals, or medical
supplies which would require including the UDI or DI in the Open Payments information. While CMS did
not directly answer many questions raised by stakeholders on implementation challenges, they indicate
additional guidance and engagement with manufacturers on implementation is forthcoming. PGS. 1110-
-1127

CY 2020 Updates to the Quality Payment Program

Merit-Based Incentive Payment System (MIPS) Provisions
CMS finalized its new MIPS Value Pathways (MVPs) framework beginning with the 2021 MIPS
performance period/2023 MIPS payment year.

CMS also finalized its proposal to strengthen the Qualified Clinical Data Registry (QCDR) measure
standards for MIPS to require measure testing, harmonization, and clinician feedback to improve the
quality of QCDR measures available for clinician reporting. In addition, CMS finalized the proposed
episode-based measures in the cost performance category to more accurately reflect the cost of care
that specialists provide and the revised total per capita cost and the Medicare Spending Per Beneficiary
(MSPB) measures.

CMS will continue to weight the cost performance category at 15 percent in light of concerns regarding
more detailed and actionable performance and will continue to weight the quality performance
category at 45 percent. CMS did not finalize its proposal to set the additional performance threshold at
80 points for the 2022 MIPS payment year and instead finalized the additional performance threshold at
85 points.

CMS estimated that there will be approximately 879,966 MIPS eligible clinicians for the 2020 MIPS
performance period. CMS also estimated that MIPS payment adjustments will be equally distributed
between negative MIPS payment adjustments ($433 million) and positive MIPS payment adjustments
($433 million) to MIPS eligible clinicians.

Alternative Payment Models (APMs) Provisions
CMS will, beginning in 2020, allow APM entities and MIPS eligible clinicians participating in APMs the
option to report on MIPS quality measures for the MIPS Quality performance category. APM entities will
receive a calculated score based on individual, TI,N, or APM entity reporting, similar to the approach for
the MIPS Promoting Interoperability performance category.
CMS estimated that, for the 2022 payment year, between 210,000 and 270,000 clinicians will become Qualifying APM Participants (QPs). CMS estimated that the total lump sum APM Incentive Payments will be approximately $535-685 million for the 2022 Quality Payment Program payment year.

The display version of the rule can be downloaded from the Federal Register website at: https://s3.amazonaws.com/public-inspection.federalregister.gov/2019-24086.pdf

You can access the CMS Fact Sheets and Press Releases on the final physician fee schedule rule at:


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