2021 Medicare Physician Fee Schedule - Final Rule

December 10, 2020

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Agenda

- Fee Schedule
- Telehealth
- Supervision of Diagnostic Tests
- Quality Payment Program (QPP)
  - Merit-Based Incentive Program (MIPs)
    - Updates
    - MVPs
  - Alternative Payment Models (APMs)
    - Updates
    - APPs

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Fee Schedule

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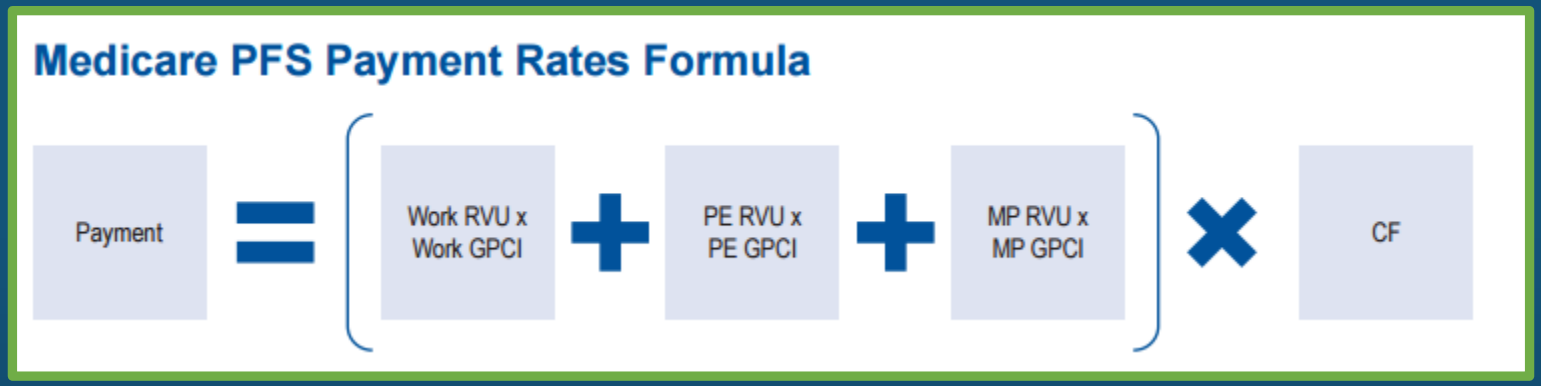
Fee Schedule

Final Conversion Factor - $32.40

- 10.2% Decrease (- $3.69) from 2020 CF of $36.09

- **Anesthesia Factor - $20.05**
  - Decrease of - $2.05 from 2020 CF of $22.20



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Fee Schedule - E/M Codes

CMS did not eliminate or delay the implementation of RVU changes for Office/Outpatient E/M codes effective January 1, 2021.

- **CMS accepted AMA's recommendation for documentation requirements and RVU's in 2019/2020**
  - **CMS moving forward with plan from 2020 Final Rule**
- **Coding for E/M visits revised to be based on time spent with patient and medical decision making**
  - **History and exam only required when medically appropriate**

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Fee Schedule - E/M Codes

	Formerly known as:	Description	Total Time	2021 Work RVU
G2211	GPC1X	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.	11	.33
G2212	CPT code 99XXX or 99417	Prolonged office or other outpatient evaluation and management service(s) beyond the minimum required time of the primary procedure which has been selected using total time, requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each additional 15 minutes (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)).	15	.61

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Fee Schedule - E/M Codes

E&M Code	2020 RVUs	2021 RVUs
New Patients		
99201	0.48	Removed
99202	0.93	0.93
99203	1.42	1.60
99204	2.43	2.60
99205	3.17	3.50
Established Patients		
99211	0.18	0.18
99212	0.48	0.70
99213	0.97	1.30
99214	1.50	1.92
99215	2.11	2.80

In addition to moving forward with E/M code changes, CMS reevaluated of the following code sets:

- End-Stage Renal Disease (ESRD) Monthly Capitation Payment (MCP)Services
- Transitional Care Management (TCM) Services
- Maternity Services
- Cognitive Impairment Assessment & Care Planning
- Initial Preventive Physical (IPPE) Examination & Initial & Subsequent Annual Wellness (AWV) Visits
- Emergency Department Visits
- Therapy Evaluations
- Psychiatric Diagnostic Evaluations & Psychotherapy Services

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Fee Schedule - Impact by Specialty

Specialty	Impact
Nurse Anes. / Anes. Assistants	-10%
Radiology	-10%
Pathology	-9%
Physical/Occupational Therapy	-9%
Cardiac Surgery	-8%
Interventional Radiology	-8%
Anesthesiology	-8%
Nuclear Medicine	-8%
General Surgery	-6%
Radiation Oncology	-5%
Colon And Rectal Surgery	-5%
Gastroenterology	-4%
Orthopedic Surgery	-4%
Hand Surgery	-3%
Dermatology	-1%
Podiatry	-1%
Clinical Psychologist	0%
Physician Assistant	8%
Allergy/Immunology	9%
Family Practice	13%
Endocrinology	16%

Specialties that commonly bill E/M codes may see increases of up to 16%

Specialties that do not are expected to see decreases of up to -10%

The final estimate of total impact to specialties remains similar (within 1%) to the estimates provided in the proposed rule

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Telehealth

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Telehealth

The COVID-19 PHE rapidly expanded telehealth utilization and access for Medicare beneficiaries

- **Pre-PHE - ~ 14,000 beneficiaries received telehealth care per week**
- **CMS estimates 10.1 million beneficiaries have utilized telehealth between March – July**

Temporary waivers and flexibilities granted by CMS/HHS during the PHE allowed providers and beneficiaries to quickly shift to telemedicine services.

CMS has made some of these flexibilities permanent in the 2021 rule

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Telehealth

CMS Telehealth List

- **The list of CPT codes reimbursable under Medicare if furnished via telehealth**

2021 Final Rule:

- **CMS has added 8 CPT codes to the list permanently**

- **CMS has finalized new criteria to temporarily add codes to the list outside of rulemaking**
  - **Allows temporary codes to stay on list until the end of the calendar year when a PHE occurs**

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

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Telehealth

Permanent Additions		Temporary 'Category 3' Additions	
99483	Care Planning for Patients with Cognitive Impairment	**99336, 99337**	Domiciliary, Rest Home, or Custodial Care services, Established Patients
99334, 99335	Domiciliary, Rest Home, or Custodial Care	**99281, 99282, 99283**	Emergency Department Visits
90853	Group Psychotherapy	**99349, 99350**	Home Visits, Established Patient
99347, 99348	Home Visits	**99315, 99316**	Nursing facilities discharge day management
96121	Neurobehavioral Status Exam	**96130, 96131 96132, 96133**	Psychological and Neuropsychological Testing
G2211	New E/M visit complexity add-on code		
G2212	New E/M prolonged service add-on code		

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Telehealth

Direct Supervision via Telehealth

- CMS is will continue allow direct supervision to be conducted via telehealth until December 31, 2021 or the end of the PHE

Audio-Only Assessment Services

- CMS has created a new HCPCs code for extended virtual services delivered via synchronous communications technology (audio only)

G2252	(Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.)

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Supervision of Diagnostic Tests

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Physician Supervision

CMS will allow NPs, CNSs, PAs, CNMs, and CRNAs to supervise the performance of diagnostic tests

- **Currently permitted under PHE waiver**
- **CMS added CRNAs to this list in the final rule**

- **These non-physician practitioners are permitted to supervise diagnostic tests within their state scope of practice effective January 1st, 2021**
  - **Provided statutory relationships with supervising or collaborating physicians is maintained**

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Quality Payment Program

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QPP: 2021 Themes

- Future QPP Framework
  - 2021 begins a split between ‘Traditional MIPS’ and new pathways for MIPS and APMs
- Major updates are focused on MIPS APMS and participants in the Medicare Shared Savings Program (MSSP)
- Impact of COVID-19
  - CMS approved flexibilities for the 2020 reporting year
  - Incorporation of telehealth into MIPS performance categories
    - EX - Quality/Cost measure updates

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MIPS Program Updates

2020 Program Flexibilities

- **Complex Patient Bonus**
  - **Worth up to 10 pts for 2020 ONLY**

- **COVID-19 Hardship Application**
  - **CMS has opened this so APM Entities can now apply**
  - **Deadline to submit extended to February 1st, 2021**

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MIPS Program Updates

Historical Performance Year Thresholds

Performance Year	Payment Year	Max Payment Adjustments	Performance Threshold	Exceptional Performance Threshold	Payment Adjustments
2017	2019	(+/ -) 4%	3 pts	70 pts	1.88%
2018	2020	(+/ -) 5%	15 pts	70 pts	1.68%
2019	2021	(+/ -) 7%	30 pts	75 pts	(1.79%) 4.67% **
2020	2022	(+/ -) 9%	45 pts	85 pts	6.25% **
2021	2023	(+/ -) 9%	60 pts	85 pts	6 – 8 % **
2022	2024	(+/ -) 9%	74 – 86 **	90 – 95 **	8+%**

**CMS forecast

CMS is required to set performance thresholds to mean or median performance rates by 2022

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MIPS Program Updates

Traditional MIPS Performance Category Weights

- Quality – 40% (- 5%)
- Cost – 20% (+ 5%)
- Improvement Activities – 15%
- Promoting Interoperability – 25%

CMS is required to weight Quality and Cost equally by 2022

APM Entity Performance Category Weights

- Quality – 50%
- Improvement Activities – 20%
- Promoting Interoperability – 30%

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MIPS Program Updates

Quality Measure Updates

- **Substantive changes to 113 existing MIPS quality measures**
  - **Telehealth and eCQM instructions – common theme**
  - **Measure specifications have not been released**
- **Removal of 11 quality measures**
- **Adding 2 new administrative claims outcome quality measures**
  - Hospital-Wide, 30-Day, All-Cause Unplanned Readmission Rate
  - Risk-standardized Complication Rate for Elective Hip/Knee Arthroplasty

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MIPS Program Updates

Quality Measure Removed in 2021	
48	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older – removed from claims based reporting only
69	Hematology: Multiple Myeloma: Treatment with Bisphosphonates
146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms
333	Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse)
348	Implantable Cardioverter-Defibrillator (ICD) Complications Rate
390	Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options
408	Opioid Therapy Follow-up Evaluation
412	Documentation of Signed Opioid Treatment Agreement
414	Evaluation or Interview for Risk of Opioid Misuse
437	Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure
458	All-Cause Hospital Readmission

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MIPS Value Pathways

- **CMS delayed the start of MIPs Value Pathways (MVPs) until 2022**

- **MVPs – condition or specialty-specific groups of cost, quality and improvement measures with a foundation of the promoting interoperability category.**

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Alternative Payment Models (APMS): MIPS APMS and Advanced APMs

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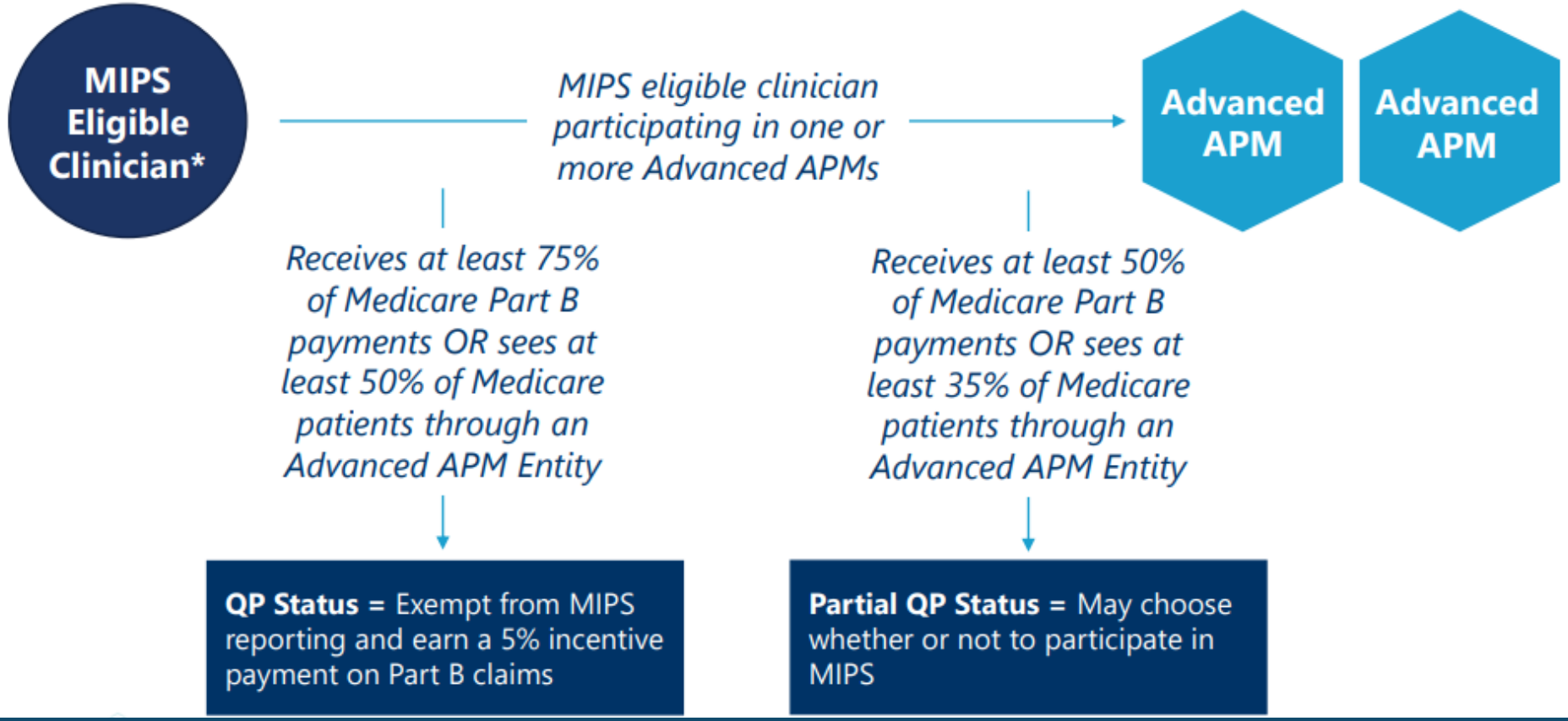
APM QPP Updates

Increased thresholds for ‘QP’ and ‘Partial QP’ status in 2021



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APM QPP Updates

‘Removal’ of the APM Scoring Standard

- APM Entity now its own submission level – maintaining the category weighting of the scoring standard
- New hierarchy for score application for multiple submissions
  - CMS will now apply the most advantageous score unless submitting as a virtual group

Sunset of the CMS Web Interface

- CMS delayed removing this as a submission option until 2022
- Still available to use in 2021 and measures applied to the APP

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APM Performance Pathway (APP)

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APM Performance Pathway

New framework for APMs/ACOs reporting starting 2021

- The APP framework is available (optional) for MIPS eligible clinicians participating in MIPS APMS
  - Can be submitted at individual, group, or APM Entity levels
- The APP is mandatory for Medicare Shared Savings Program (MSSP) ACOs
  - CMS is aligning quality reporting for both MSSP and QPP so the APP fulfills both
- Same concept as an MVP but not specific to specialties/conditions

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APM Performance Pathway

APP for APM participants

Quality	Promoting Interoperability	Improvement Activities	Cost
Diabetes: Hemoglobin A1c (HbA1c) Poor Control	All standard measures in the PI category	Automatic score of 100%	None
Preventive Care and Screening: Screening for Depression and Follow-up Plan			
Controlling High Blood Pressure			
Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate			
Risk Standardized, All Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs			
CAHPS for MIPS Survey			

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APM Performance Pathway

APP for ACO (MSSP) participants

Quality	Promoting Interoperability	Improvement Activities	Cost
Diabetes: Hemoglobin A1c (HbA1c) Poor Control	Not required to participate in the remaining MIPs categories		
Preventive Care and Screening: Screening for Depression and Follow-up Plan			
Controlling High Blood Pressure			
Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate			
Risk Standardized, All Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs			
CAHPS for MIPS Survey			

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Final Rule Resources

- CMS Final Rule
- 2021 Final Rule Supporting Documents
- CMS Fact Sheet
- QPP - Resource Library

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Thank you!

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