Summary of 2021 Changes to the Medicare Physician Fee Schedule, Quality Payment Program, and Other Federal Programs

Updated 12/23/20

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Updates to the Physician Fee Schedule

Introduction

On December 2, 2020, the Centers for Medicare & Medicaid Services (CMS) published the final rule for the Medicare Physician Fee Schedule (MPFS) and the Quality Payment Program (QPP) for Calendar Year (CY) 2021. The final rule updates payment rates and polices for services supplied under the PFS on or after Jan. 1, 2021. Access the CMS press release for more information and links to relevant fact sheets.

For this final rule to maintain budget neutrality, the finalized 2021 conversion factor is $32.41. However, due to legislative changes, the actual 2021 conversion factor is expected to be higher. Internal medicine will see a net positive four percent impact. According to Table A below (based on Table 106 in the final rule), the overall estimated impact on total allowed charges for internal medicine and its subspecialties will be:

Regulatory Impact Analysis (CMS)

Table A: Overall estimated impact on total allowed charges for internal medicine and subspecialties*

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
ALLERGY/IMMUNOLOGY	$247	5%	4%	0%	9%
CARDIOLOGY	$2,020	1%	0%	0%	1%
CRITICAL CARE	$378	-6%	-1%	0%	-7%
ENDOCRINOLOGY	$508	10%	5%	1%	16%
GASTROENTEROLOGY	$1,757	-3%	-1%	0%	-4%
GERIATRICS	$192	1%	1%	0%	3%
HEMATOLOGY/ONCOLOGY	$1,707	8%	5%	1%	14%
INFECTIOUS DISEASE	$656	-4%	-1%	0%	-4%

to decide the level of office/outpatient E/M visit, along with updated CPT guidelines for both options.

In the 2021 final rule, CMS will adopt the actual total times for CPT codes 99202 through 99215 on the date of encounter while moving forward with the valuation and code selection guideline changes.

Visit Complexity

CMS has finalized its proposal to implement a Medicare-specific add-on code (G2211) for E/M office visits that describe the complexity associated with visits 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 condition or a complex condition. However, this code will not be implemented in 2021 due to legislative changes prohibiting its implementation until at least 2024.

Psychiatric Collaborative Care Model (CoCM) Services

In the 2021 proposed rule, CMS proposed establishing a new code, GCOL1 that would describe 30 minutes of behavioral health care manager time. The code would be described as: "Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care

office visit level of coding and when the minimum time for the level 5 office visit (99205 or 99215) is exceeded by at least 15 minutes. For example, practitioners could bill 99417 in conjunction with 99205 (60-74 minutes of total time) when they have spent at least 89 minutes with the patient and with 99215 (40-54 minutes) when they have spent at least 69 minutes with the patient.

However, in the final rule, CMS noted that they will not be finalizing this proposal. The Agency notes that it "…continues to believe that CPT code 99417 as written is unclear and that allowing reporting of CPT code 99417 when the minimum required time for the level 5 visit is exceeded by at least 15 minutes would result in double counting time." Instead, CMS is finalizing policy

The agency did not propose to add any codes to the telehealth list on a Category 2 basis. However, CMS is finalizing its proposal to create a new, Category 3 level that would add services to the telehealth list on a temporary basis through the end of the calendar year in which the public health emergency (PHE) expires. These services include:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337)
- Home Visits, Established Patient (CPT 99349-99350)
- Emergency Department Visits, Lev

In the office setting, "direct supervision" means the physician (or other supervising practitioner) must be present in the office and immediately available to furnish assistance and direction to the clinician performing the service throughout the performance of the procedure. Direct supervision does not mean that the physician/supervising practitioner must be present in the room. In an effort to limit the exposure of COVID-19, CMS proposed to extend until the end of 2021 the ability of supervising physicians or practitioners to use interactive audio/video real-time communications technology to supervise directly. The Agency has finalized an extension of this policy through the end of the CY in which the PHE ends, or December 31, 2021. CMS did not finalize any policy to permanently extend this. This provision applies to qualified health professionals (QHPs)/clinicians, not residents.

Care Management

Remote Physiologic Monitoring (RPM)

In the final rule, CMS clarified its payment policies related to RPM services codes 99453, 99454, 99091, 99457, and 99458. CMS also clarified that following expiration of the COVID-19 PHE, there must be an established patient-physician relationship for RPM services to be furnished – ending its interim policy permitting RPM services to be furnished to new patients. The Agency also finalized policy allowing consent to receive RPM services to be obtained at the time RPM services are furnished.

CMS' final rule further provides for a number of modifications to RPM codes beginning in 2021:

- Allowing auxiliary personnel to furnish CPT codes 99453 and 99454 services under a physician's supervision;
- That medical devices supplied to a patient as part of RPM services must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act, that the device must.9(i)7nA/P 2(an45)-6(
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End Stage Renal Disease Services (for ages less than 2 months through 20+ years)	90951	ESRD related services with 4 or more face-to-face visits per month; for patients younger than 2 years
	90954	ESRD related services with 4 or more face-to-face visits per month; for patients 2-11 years
	90955	ESRD related services with 2-3 face-to-face visits per month; for patients 2-11 years
	90956	ESRD related services with 1 face-to-face visit per month; for patients 2-11 years

CMS will finalize for the duration of the COVID-19 PHE, the ability for residents to furnish telehealth services to beneficiaries with the teaching physician present using interactive, audio/video real-time communications technology (excluding audio-only).

At the conclusion of the PHE, however,

In the proposed rule, CMS proposed to revalue the immunization administration codes by cross-walking

CMS finalized several modifications and additions to the MVP guiding principles and development criteria to emphasize the importance of patient voice and supporting the transition to digital quality measures. Beginning with PY 2022, stakeholders must formally submit MVPs utilizing a standardized template, which would be published in the QPP resource library. CMS will host an annual MVP development webinar detailing development criteria, timeline, and process. The Agency will not communicate to stakeholders whether an MVP candidate has been approved, disapproved, or is being considered for a future year prior to the publication of the proposed rule. QCDR measures may be included in candidate MVPs provided they were approved the previous year and meet all testing criteria.

Performance Year 2021 MIPS Changes

Extreme and Uncontrollable Circumstances Policy

CMS extended the MIPS extreme and uncontrollable circumstances policy due to the COVID-19 PHE through the PY 2021. Applications for PY 2021 are due Dec. 31, 2021. Individual clinicians, groups, and virtual groups may apply to reweight one or more performance categories. If data is received for two or more performance categories, this will supersede exception requests and the clinician would receive a MIPS score and payment adjustment. CMS also extended the deadline for PY 2020 hardship applications due to the COVID-19 PHE to Feb 1, 2021.

Beginning with PY 2020, applications may also be submitted at the APM Entity level. APM Entities must demonstrate that 75% or more of clinician participants are eligible for reweighting for the Promoting Interoperability (PI) Category. If the request is approved, all MIPS Eligible Clinicians (ECs) participating in the APM Entity would be exempt from MIPS reporting for the applicable performance period, and the APM Entity would receive a final score equal to the performance threshold and a neutral payment adjustment. Such requests for reweighting would be approved or denied in their entirety. For APM Entities, data reported would not void the reweighting request.

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When multiple MIPS scores are associated with a single TIN/NPI combination, CMS will use the highest available MIPS score regardless of how data was submitted (whether by an individual clinician, group, or APM Entity). This represents a change from previous policy in which CMS used a systematic hierarchy.

CMS released PY 2019 feedback on Aug. 5, 2020. Additional information is available at https://qpp.cms.gov/about/deadlines?py=2019.

Cost Category

- **Case minimums for administrative claims measures** will be individually specified on the annual list of MIPS measures.
- **CAHPS for MIPS Survey:** For PY 2020 and any subsequent performance year impacted by the COVID PHE, CMS will: 1) add a new measure to assess patient-reported use of telehealth; and 2) count several telehealth services towards beneficiary assignment.

The first criterion for scoring would be that the measures have been topped out for 2 or more periods based on the published 2020 MIPS performance period historical benchmarks (which are based on submissions for the 2018 MIPS performance period). The second criterion would be the measures

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- Diabetes: Hemoglobin A1C Poor Control (QID #001)**
- Screening for Depression and Follow Up Plan (QID #134)**
- Controlling High Blood Pressure (QID #236)**

* The finalized MCC measure aligns the ACO MCC measure with the MIPS MCC measure by (1) adding a diabetes cohort; (2) excluding any admissions within 10 days of discharge from a hospital, SNF, or acute rehabilitation facility; and (3) adjusting for the AHRQ SES index and specialist density social risk factors.

** For 2021 only, in lieu of the three eCQMs, ACOs can chose to report the 10 ACO Web Interface measure set. CMS Web Interface will be removed as an available reporting mechanism in 2022.

All of the quality measures available for reporting through the APP for PY 2021 are summarized in Table 47. Reporters will receive a zero for measures they fail to report. Measures that fail to meet specified patient population o

CMS finalized a new 60-

ACOs whose agreement periods began July 1, 2019 or Jan. 1, 2020 have a one-time opportunity to elect to reduce the amount of their repayment mechanisms if they used an existing repayment mechanism, the o

{ o DPP suppliers must be authorized to furnish services in-person, even if they elect to do so virtually during emergencies. This is intended to minimize disruption when emergency crises end.

For a full summary of MDPP specific policies finalized in this rule, access this CMS fact sheet.

Code List for Certain Designated Health Services (DHS) for purposes of Stark Law

The updated code list effective Jan. 1, 2021 can be found here. Generally, COVID-19 tests and vaccines are considered designated health services, as they fall within the category of "clinical laboratory services."