Medicare Physician Fee Schedule

2021 Proposed Rule

Outline

- PFS Background
- Summary of Proposed Changes
- Significant changes for employed provider networks and potential impact

Medicare PFS Background

Medicare Physician Fee Schedule

- Physician Fee Schedule
  - Determines reimbursement requirements and rates
  - Applies to payment for services provided by physicians and other practitioners at all sites of service
- 2021 Proposed Rule
  - Released August 3, 2020
  - Published in Federal Register August 17, 2020
  - Available for detailed review at

    https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-p
  - Public Comment period closes October 4th
  - Final Rule usually released 1st week in November
    - Anticipated to be delayed until the 1st of December due to COVID workload

2021 Proposed Rule

- Major themes remain the same as for the 2020 Final Rule
  - Desire to respond to requests to reduce administrative burden of healthcare
    - Patients over Paperwork
  - Desire to improve accuracy of outpatient E&M coding and payment process
  - Desire to consider impact of evolving health care delivery
    - Create a system that results in better accessibility, quality, affordability, empowerment, and innovation

Summary of Changes

2021 Proposed Rule – Summary of Changes

- Conversion Factor decreased to $32.26
- Office E&M coding changes
  - Affects New and Established patient codes (99201-5, 99211-5)
  - Eliminates 99201
  - Increased wRVU value for most codes
  - Coding based on time spent and medical decision-making complexity
  - Adopted new time spent parameters by code
  - Created two new add-on codes for
    - Additional time spent on extended visits (99XXX)
    - Greater complexity for certain visits (GPC1X)
- Telehealth services
  - Permanent changes
  - PHE-limited changes
  - Telephone considerations
  - SNF visit frequency
  - Virtual direct supervision

2021 Proposed Rule – Summary of Changes

- Scope of Practice
  - NPs, CNSs, CNMs, PAs can supervise the performance of diagnostic tests
    - Previously could order but only physicians could supervise
  - Pharmacists included in auxiliary personnel under "incident to" regs
  - Permanence of PT and OT delegation of maintenance care to PTAs and OTAs
- Communication Technology-Based Services (CTBS)
  - Non-face-to-face care not subject to telehealth regulations
    - e.g., virtual check-in
  - Consent can be obtained and documented by auxiliary staff under general supervision
  - Permits LCSW, clinical psychologists, PT, OT, speech pathologists to bill G2061-2063 for online assessment of established patients
    - Adds new virtual check-in code (G20X2) and images code (G20X0)

2021 Proposed Rule – Summary of Changes

- Remote Physiologic Monitoring (RPM)
  - Indicates will return to established patient limitation after PHE
  - Clarified existing policies
    - Including that consent can be obtained at time services are furnished
- Clinical Laboratory Fee Schedule (CLGS)
  - Payment decreases delayed – as permitted in the CARES Act
- Appropriate Use Criteria (AUC)
  - Separately announced (8/10) extension of educational and testing period through 2021
    - No payment consequences until at least 2022
- Rebase and revise FQHC Market Basket
  - Reflect 2017 base year
  - Market basket increase of 2.5%
  - Multifactor productivity adjustment of 0.6%

2021 Proposed Rule – Summary of Changes

- Medicare Shared Savings Program (MSSP)
  - Updates primary care definition for beneficiary assignment process
  - Revises how repayment amounts determined for two-sided models
  - Eliminates Web interface reporting mechanism
    - Replaces with new "APM Performance Pathway"
      - Accomplishes both MSSP and MIPS reporting process
  - Decreases number of quality measures that ACO must report
    - 23 to 6
  - Increase minimum quality performance threshold to 40th percentile
    - Estimates that 95% of ACOs would achieve that score (based on 2018 data)

Significant Changes and Impact

Proposed Conversion Factor for 2021

- Required to maintain budget neutrality when changes in wRVUs made
- 2021 Conversion Factor proposed to be $32.26
  - Compared to 2020 rate of $36.09
  - Absolute decrease of $3.83 or 10.6%
  - Recent consistency year to year
    - Compared to 2019 rate of $36.04
    - Compared to 2018 rate of $35.99
- Impact will not be uniform across specialties
- AMA and other professional societies indicate opposition to this degree of decrease in a single year
  - Propose waiver of budget neutrality, delayed implementation to allow for adjustment interval, or phased implementation approach to the changes
    - Phased approach would require reduced increases in wRVU values compared to proposed levels

Proposed Compensation Impact by Specialty

- Anticipated impact on Total Allowed Charges by specialty based on wRVU changes varies from -11% to +17%
- Examples include

Positive		Neutral		Negative	
Endocrinology	17%	Clinical Pscyhology	0%	Radiology	-11%
Heme/Onc	14%	Clinical Social Work	0%	CRNA	-10%
Family Practice	13%	Cardiology	1%	Chiropractor	-10%
Allergy	9%	Pulmonology	1%	Interventional Radiology	-9%
NP, PA	8%	Podiatry	-1%	Cardiac Surgery	-9%
OB/GYN	8%	Dermatology	-2%	Thoracic Surgery	-8%
ENT	7%			Anesthesiology	-8%
				Vascular Surgery	-7%
				General Surgery	-7%
				Neurosurgery	-7%
				Plastic Surgery	-7%

Table 90 of Proposed Rule - CMS-1734-P, Federal Register / Vol. 85, No. 159 / Monday, August 17, 2020 / Proposed Rules 50375

Proposed wRVU Changes for E&M Codes

- Stated purposes for increasing wRVU values for E&M codes include
  - Remove regulatory obstacles that impeded physicians' ability to spend time with patients
  - Recognize the added physician responsibilities associated with office encounters
    - Greater patient complexity
    - Increased non-patient interactions responsibilities
      - EMR documentation
      - Patient status documentation
      - Care coordination

Proposed wRVU Changes for E&M Codes

HCPCS Code	Current wRVU	2021 Proposed wRVU
99201	.48	N/A
99202	.93	.93
99203	1.42	1.6
99204	2.43	2.6
99205	3.17	3.5
99211	.18	.18
99212	.48	.7
99213	.97	1.3
99214	1.5	1.92
99215	2.11	2.8
99XXX	N/A	.61
GPC1X	N/A	.33

MGMA, Proposed 2021 Medicare Physician Payment and Quality Reporting Changes MGMA Member-Exclusive Analysis. August 14, 2020.
https://www.mgma.com/getattachment/Resources/Resources/Government-Programs/Member-exclusive-analysis-Proposed-2021-Medicare/2021-PFS-and-QPP-proposed-rule-analysis-Final-V-2.pdf.aspx?ext=.pdf&lang=en-US

Proposed wRVU Changes – Specialty Impact

Percent Change in wRVUs from 2019 versus 2021	Number of Specialties	Percent of Specialties
0%	8	8.0%
Less than 3%	21	21.0%
3%-5.9%	21	21.0%
6%-10.9%	25	25.0%
11%-15.9%	14	14.0%
16%-20.9%	8	8.0%
21% or Greater	3	3.0%
Total	**100**	**100%**

Sullivan Cotter, 2021 Evaluation and Management CPT Codes: Understanding the Impact on Physician Compensation. American Association for Physician Leadership News, August 6, 2020.

Proposed wRVU Changes – Specialty Impact

Specialty	2019 Median wRVUs[1]	2021 Estimated wRVUs[1]	Estimated wRVU Changes
Urgent Care	4,833	6,043	25.0%
Rheumatology	4,204	5,085	21.0%
Occupational and Environmental Medicine	2,788	3,360	20.5%
Oncology – Hematology and Oncology	5,145	6,162	19.8%
Family Medicine	4,486	5,336	18.9%
Endocrinology	4,571	5,411	18.4%
Internal Medicine	4,432	5,227	17.9%
Dermatology	6,414	7,316	14.1%
Allergy/Immunology	4,128	4,647	12.6%
Pediatrics – General	5,087	5,698	12.0%
Psychiatry – General	4,479	4,963	10.8%
Neurology	4,866	5,375	10.5%
Otolaryngology – General	6,299	6,819	8.3%
Orthopedic Surgery – General	8,712	9,192	5.5%

[1] Source: 2019 *SullivanCotter Large Clinic® CPT Benchmark Study*

2021 estimates predicated on assumption that actual wRVU assignments will not change

Sullivan Cotter, 2021 Evaluation and Management CPT Codes: Understanding the Impact on Physician Compensation. American Association for Physician Leadership News, August 6, 2020.

Proposed Revaluation of E&M services

- Value of the following proposed to increase in 2021
  - End-Stage Renal Disease (ESRD) Monthly Capitation Payment (MCP) Services
  - Transitional Care Management (TCM) Services
  - Maternity Services
  - Cognitive Impairment Assessment and Care Planning
  - Initial Preventive Physical Examination (IPPE) and Initial and Subsequent Annual Wellness (AWV) Visits
  - Emergency Department Visits
  - Therapy Evaluations
  - Psychiatric Diagnostic Evaluations and Psychotherapy Services
  - Vaccine administration

Impact of Proposed wRVU Changes – Comp/wRVU

- Increases in compensation for various CPT codes will not offset the changes in wRVUs
- Compensation will remain constant or slightly decreased for most specialties while wRVU levels increase
- In many instances, compensation per wRVU ratios will change – and in many cases will decrease

Proposed wRVU Impact by Specialty

Specialty	Column A: Estimated % Change in Clinical Compensation	Column B: Estimated % Change in wRVU	Column C: Estimated % Change in Compensation per wRVU
Urgent Care	20%	25%	-4%
Rheumatology	12%	21%	-6%
Occupational and Environmental Medicine	14%	21%	-2%
Oncology – Hematology and Oncology	11%	20%	-6%
Family Medicine	15%	19%	-3%
Endocrinology	10%	18%	-5%
Internal Medicine	12%	18%	-5%
Dermatology	10%	14%	-4%
Allergy/Immunology	8%	13%	-4%
Pediatrics – General	9%	12%	-3%
Psychiatry – General	7%	11%	-3%
Neurology	6%	10%	-4%
Otolaryngology – General	5%	8%	-2%
Orthopedic Surgery – General	4%	6%	-1%

Sullivan Cotter, 2021 Evaluation and Management CPT Codes: Understanding the Impact on Physician Compensation. American Association for Physician Leadership News, August 6, 2020.

Proposed E&M Changes

- Maintained the 2020 Final Rule re: coding and reimbursement of E&M office/outpatient visits
  - Consistent with the CPT Editorial Panel for office/outpatient E/M visits
  - Changes include
    - Maintaining all 5 levels for Established Patients – 99211 to 99215
    - Eliminating 99201 for New Patients as same level of decision-making as 99202
      - Difference was solely the required history and physical examination components
    - Permitting E&M level determination by either medical decision-making or time
    - Revising the times and medical decision-making process for all codes
    - Requiring performance of history and examination only as medical appropriate
      - These will no longer be the defining criteria they were for the 1995 and 1997 guidelines
    - Creating new add-on CPT codes for prolonged service time

Proposed E&M Changes – New Add-on CPT Codes

- CPT code 99XXX
  - Used to add additional time beyond the base parameter for total time spent on patient encounter – same date of service only
  - Each additional 15 minute increment
  - Only applies to the 99205 and 99215 codes when using time as coding determinant
  - Listed in addition to the 99205 or 99215 codes
- HCPCS code GPC1X
  - Adds additional wRVU credit for visit complexity associated with patient's single, serious, or complex chronic condition
  - Details still being defined
    - May generate incremental wRVU credit of 0.33

Proposed E&M Coding Criteria – Time

- Code based on amount of time provider dedicated to patient on day of service – referred to as total time
  - Face-to-face time with patient
  - Indirect care time dedicated to that patient interaction the same day
    - Reviewing tests
    - Obtaining or reviewing separately obtained history
    - Ordering medications, tests, or procedures
    - Documenting in the EHR
    - Communicating with patients/caregiver/family
    - Communicating with consultants related to the patient encounter or orders
- CMS revised times per E&M code
  - Increased total time required to achieve most codes
  - May result in assignment of lower coding level for same amount of time expended
    - May decrease total wRVUs achieved rather than anticipated increase

Proposed E&M Coding Criteria – Time

HCPCS Code	Current Minimum Minutes per Visit	Current wRVU for Code	2021 Minutes per Visit	2021 wRVU for Code	Percentage Increase in wRVU Value
99201[1]	17	0.48	N/A	N/A	N/A
99202	22	0.93	22	0.93	0%
99203	29	1.42	40	1.60	13%
99204	45	2.43	60	2.60	7%
99205	67	3.17	85	3.50	10%
99211	7	0.18	7	0.18	0%
99212	16	0.48	18	0.70	46%
99213	23	0.97	30	1.30	34%
99214	40	1.50	49	1.92	28%
99215	55	2.11	70	2.80	33%
99XXX[2]	N/A	N/A	15	0.61	N/A
GPC1X[3]	N/A	N/A	11	0.33	N/A

[1] This code to be eliminated in 2021.
[2] This is an add-on code for every 15 minutes of extended patient office visit time.
[3] This code is an add-on code to recognize complexity for qualified chronic patient conditions.

Sullivan Cotter, 2021 Evaluation and Management CPT Codes: Understanding the Impact on Physician Compensation. American Association for Physician Leadership News, August 6, 2020.

Proposed E&M Coding Criteria – Medical Decision-Making

- With elimination of history and examination requirements, criteria applied to MDM changes
- Impact should have little impact on assigned wRVU per encounter nor future v. historic wRVU productivity
- MDM always part of the 1995 and 1997 coding criteria, but above changes may have significant impact on encounter documentation
  - EMR documentation templates focused on 1995 and 1997 criteria, which were heavily weighted toward inclusion of history and physical examination components
  - EMR documentation historically light on differential diagnosis and thought process documentation
    - Usually required "free text" comments
    - Expounding on these elements often inferred and secondary in importance to checking sufficient history and physical examination boxes
    - Higher emphasis on these elements in 2021 MDM criteria
- Education and audit issue

Proposed E&M Coding Criteria – Medical Decision-Making

Table 2 – CPT E/M Office Revisions
Level of Medical Decision Making (MDM)

Revisions effective January 1, 2021:

Note: this content will not be included in the CPT 2020 code set release

Code	Level of MDM (Based on 2 out of 3 Elements of MDM)	Elements of Medical Decision Making		
		Number and Complexity of Problems Addressed	Amount and/or Complexity of Data to be Reviewed and Analyzed **Each unique test, order, or document contributes to the combination of 2 or combination of 3 in Category 1 below.*	Risk of Complications and/or Morbidity or Mortality of Patient Management
99211	N/A	N/A	N/A	N/A
99202 99212	Straightforward	**Minimal** • 1 self-limited or minor problem	**Minimal or none**	**Minimal risk of morbidity from additional diagnostic testing or treatment**

99203
99213
	Low	**Low**
		• 2 or more self-limited or minor problems;
		or
		• 1 stable chronic illness;
		or
		• 1 acute, uncomplicated illness or injury
			Limited
			(Must meet the requirements of at least 1 of the 2 categories)
			Category 1: Tests and documents
			• **Any combination of 2 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ review of the result(s) of each unique test*;
			  ▪ ordering of each unique test*
			or
			Category 2: Assessment requiring an independent historian(s)
			(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high)
				Low risk of morbidity from additional diagnostic testing or treatment

99204
99214
	Moderate	**Moderate**
		• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;
		or
		• 2 or more stable chronic illnesses;
		or
		• 1 undiagnosed new problem with uncertain prognosis;
		or
		• 1 acute illness with systemic symptoms;
		or
		• 1 acute complicated injury
			Moderate
			(Must meet the requirements of at least 1 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ Review of the result(s) of each unique test*;
			  ▪ Ordering of each unique test*;
			  ▪ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				Moderate risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Prescription drug management
				• Decision regarding minor surgery with identified patient or procedure risk factors
				• Decision regarding elective major surgery without identified patient or procedure risk factors
				• Diagnosis or treatment significantly limited by social determinants of health

99205
99215
	High	**High**
		• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;
		or
		• 1 acute or chronic illness or injury that poses a threat to life or bodily function
			Extensive
			(Must meet the requirements of at least 2 out of 3 categories)
			Category 1: Tests, documents, or independent historian(s)
			• **Any combination of 3 from the following:**
			  ▪ Review of prior external note(s) from each unique source*;
			  ▪ Review of the result(s) of each unique test*;
			  ▪ Ordering of each unique test*;
			  ▪ Assessment requiring an independent historian(s)
			or
			Category 2: Independent interpretation of tests
			• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**
			or
			Category 3: Discussion of management or test interpretation
			• Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)
				High risk of morbidity from additional diagnostic testing or treatment
				Examples only:
				• Drug therapy requiring intensive monitoring for toxicity
				• Decision regarding elective major surgery with identified patient or procedure risk factors
				• Decision regarding emergency major surgery
				• Decision regarding hospitalization
				• Decision not to resuscitate or to de-escalate care because of poor prognosis

https://www.ama-assn.org/system/files/2019-06/cpt-revised-mdm-grid.pdf

Proposed Rule – Telehealth

- Proposed permanent additions to covered services (9)
  - Visit complexity associated with office/outpatient E/M services (GPC1X)
  - Prolonged services (99XXX)
  - Group psychotherapy (90853)
  - Neurobehavioral status exam (96121)
  - Care planning for patients with cognitive impairment (99483)
  - Domiciliary, rest home, or custodial care services (99334-99345)
  - Home visits, established patient (99347-99348)
- Proposed extensions through end of calendar year in which the COVID PHE ends (13)
  - Domiciliary, rest home, or custodial care services, established patients (99336-99337)
  - Home visits, established patient (99349-99350)
  - Emergency department visits (99281-99283)
  - Nursing facilities discharge day management (99315-99316)
  - Psychological and neuropsychological testing (96130-96133)

Proposed Rule – Telehealth

- Discontinues payment for audio-only visits (99441-99443) as expected
  - Solicits public comment whether CMS should develop coding and payment for these services
- Revises frequency limitation for subsequent SNF visits from once every 30 days to once every 3 days
- Extends policy that direct supervision can be accomplished virtually using real-time audio or video communication with supervising practitioner throughout 2021

Appropriate Use Criteria (AUC)

- Established by the Protecting Access to Medicare Act (PAMA) of 2014 (Section 218(b))
  - New program to increase the rate of appropriate advanced diagnostic imaging services provided to Medicare beneficiaries.
- Applies to
  - Computed Tomography (CT)
  - Magnetic Resonance Imaging (MRI)
  - Positron Emission Tomography (PET)
  - Nuclear Medicine

Appropriate Use Criteria (AUC)

- Design – At the time a practitioner orders an advanced diagnostic imaging service for a Medicare beneficiary, he/she, or clinical staff acting under his/her direction, will be required to consult a qualified Clinical Decision Support Mechanism (CDSM)
  - CDSMs are electronic portals through which appropriate use criteria (AUC) is accessed
  - The CDSM provides a determination of whether the order adheres to AUC, or if the AUC consulted was not applicable (e.g., no AUC is available to address the patient's clinical condition)
  - A consultation must take place at the time of the order for imaging services in defined settings and payment systems
  - Practitioners whose ordering patterns are considered outliers will be subject to prior authorization

Appropriate Use Criteria (AUC)

- Implementation – Was to be fully implemented on January 1, 2022
  - AUC consultations with qualified CDSMs are required to occur along with reporting of consultation information on the furnishing professional and furnishing facility claim for the advanced diagnostic imaging service
  - Claims that fail to append this information will not be paid


HSG | Thank You