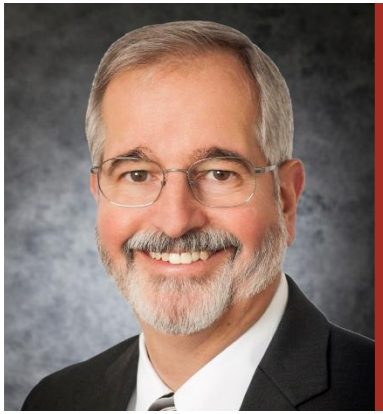
# 2021 Medicare Physician Fee Schedule

## Final Rule




# DR. TERRY McWILLIAMS

MD, MSJ, FAAFP

**DIRECTOR & CHIEF CLINICAL CONSULTANT**

Email: TMCWilliams@HSGadvisors.com

Office: (502) 614-4292

Cell: (502) 419-1954


HSG


**9850 Von Allmen Court**
**STE 201**
**Louisville, KY 40241**
www.HSGadvisors.com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- Worked with client executives and physicians to create shared visions that led to significant advances in network function and outcomes

## PROFESSIONAL EXPERIENCE

After retiring from Naval service, Dr. McWilliams spent a decade as the Vice President of Medical Affairs and Chief Medical Officer at Newport Hospital, a non-teaching community hospital within a larger academic health system. As CMO, he supervised the Medical Staff Services Office and was additionally responsible for quality of care/patient safety/risk management, clinical information systems, physician recruitment and clinical service line development. At the system level, he was intimately involved in creating system-wide Medical Staff Bylaws, spearheading various clinical IT projects, and contributing to broad-based performance improvement efforts.

## EDUCATION

Terry received his MD from the University of Pittsburgh School of Medicine and completed family medicine residency in the Navy. He completed a Master of Science in Jurisprudence (MSJ) in Hospital and Health Law from Seton Hall University School of Law.

# Special thanks to

**NEAL D. BARKER**
MBA
**PARTNER**
Email: NBarker@HSGadvisors.com
Office: (502) 814-1189
Cell: (502) 386-9821

**20+ Years in Physician Practice Management and Consulting**

**Expertise in:**
- Fair Market Value and Compliance
- Provider Compensation Models
- Physician Strategy Development
- Practice Performance Improvement

**ERIC ANDREOLI**
MBA
**DIRECTOR**
Email: EAndreoli@HSGadvisors.com
Office: (502) 814-1193
Cell: (502) 322-2087

**8 Years in Management Consulting for Health Systems and Employed Physician Networks**

**Expertise in:**
- Network Integrity
- Performance Improvement
- Benchmarking
- Compensation Planning

**For their expert assistance with developing this presentation**

# Outline

- Medicare PFS Background
- Summary of Changes
- E/M Coding Documentation
  - Total Time
  - MDM
- E/M Code wRVU Changes
- 2021 Conversion Factor
- Reimbursement Impact
- Provider Compensation 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
  - Public Comment period closed October 4th
- Final Rule December 1st (late in day)
  - Usually released by November 1st but delayed due to COVID workload
  - Available for review at https://public-inspection.federalregister.gov/2020-26815.pdf
  - To be published in the Federal Register on December 28, 2020

# 2021 Final 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 Final Rule – Summary of Changes

**The "Big Three"**

- Office E/M coding documentation changes
  - Affects E/M codes 99202-99205, 99211-99215
  - Coding based on total time spent on day of service and revised medical decision-making (MDM) complexity
  - Eliminates 99201 – same MDM as 99202
- Increased wRVU value for E/M codes 99203-99205, 99212-99215
  - Trickle down effect for many other E/M codes
    - Notably ESRD, maternity care, IPPE/AWV, TCM, ED, Psych services
- Conversion Factor decreased to $32.41 – a 10.2% decrease
  - Required to maintain budget neutrality of wRVU increases
  - Appeals being made to Congress for relief in 2021
    - Similar to previous SGR relief appeals

# 2021 Final Rule – Summary of Changes

## Additional Significant Changes

- Telehealth services
  - Permanent additions to authorized list (Category 1)
    - Home visits (established patient) (99347-99348)
    - Cognitive assessment and care planning services (99483)
    - Domiciliary, Rest Home or Custodial Care Services (99334-99335)
    - Group Psychotherapy (90853)
    - Psychological and Neuropsychological Testing (96121)
    - Prolonged Services (G2212)
    - Visit Complexity (G2211)
  - PHE-limited changes (Category 3)
    - Extended coverage through the end of the CY that PHE ends
    - Includes ED Visits, PT/OT Therapy, CCM (incl PICU, NICU), Hospital day of discharge, Observation subsequent care and discharge

# 2021 Final Rule – Summary of Changes

## Additional Significant Changes (continued)

- Telehealth services (continued)
  - SNF visit frequency
    - Subsequent care frequency increased to every 14 days as opposed to every 30 days (proposed every 3 days)
  - Telephone only
    - Confirmed that CMS will discontinue payment for audio-only visits (99441-99443) after the PHE as expected
    - Solicited public comment whether CMS should develop future coding and payment for these services

# 2021 Final Rule – Summary of Changes

## Additional Significant Changes (continued)

- Telehealth services (continued)
  - Virtual direct supervision
    - Extended policy that direct supervision can be accomplished virtually using real-time audio/video communication with supervising practitioner through the later of the PHE or the end of 2021
      - Patient safety concern prevented global permanent adoption
      - Verified non-COVID PHE requirement to be immediately available but not necessarily in same room
    - Finalized permanent adoption of virtual precepting/supervision outside of Metropolitan Statistical Areas (MSAs) to increase rural access to care and promote rural residency opportunities

# 2021 Final Rule – Summary of Changes

## Additional Significant Changes (continued)

- Communication Technology-Based Services (CTBS)
  - Non-face-to-face care not subject to telehealth regulations
    - e.g., Virtual Check-in (G2012), Virtual Images (G2010)
  - Consent can be obtained and documented by auxiliary staff under general supervision
  - Permits LCSW, clinical psychologists, PT, OT, speech pathologists to bill for online assessment of established patients
    - Replaced G2061-63 with CPT codes 98970 – 98972
    - Added new virtual check-in code (G2251) and virtual images code (G2250) and related permissions
  - Adds code G2252
    - Essentially a virtual check-in encounter that lasts 11-20 minutes
      - Synchronous communication by a QHP - can include audio only
    - Requirements of G2012 with value of 99442 (wRVU = 0.5)

# 2021 Final Rule – Summary of Changes

**Additional Significant Changes** (continued)

- Remote Physiologic Monitoring (RPM)
  - Indicated will return to established patient limitation after PHE
  - Permit auxiliary personnel to provide services under 99453 (initial set up) and 99454 (data transmission) under supervision of and incident to billing practitioner's services
  - Clarified existing policies
    - Including that consent can be obtained at time services are furnished
    - After COVID, 16 days of data each 30 days must be collected and transmitted to bill 99453 and 99454
      - Can be billed only once per 30-day period
    - Data must be automatically collected and transmitted electronically
      - Cannot be self-reported
    - Applies to medically necessary acute and chronic conditions
    - Clarified that for 99457 and 99458
      - Interaction is real time, synchronous two-way communication that can eb enhanced by video (similar to G2012)
      - The 20-minute time requirement can include care management activities

# 2021 Final Rule – Summary of Changes

**Additional Significant Changes** (continued)

- Scopes of Practice
  - NPs, CNSs, CNMs, CRNAs, 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
    - Not statutorily designated QHP so cannot bill Medicare directly for services rendered
  - Permanent permission for PT and OT delegation of maintenance care to PTAs and OTAs
    - Reimbursement to be set at 85%

# 2021 Final Rule – Summary of Changes

**Additional Significant Changes** (continued)

- Initial Preventive Physical Examination (IPPE) and Annual Wellness Visit (AWV) will include screening for potential substance use disorders (SUDs) and a review of any current opioid prescriptions.
  - Mandated by Section 2002 of the SUPPORT Act
- New code for 30 minutes of psychiatric care management – G2214
  - Initial or subsequent psychiatric collaborative care management, first 30 minutes in a month of behavioral health care manager activities, in consultation with a psychiatric consultant, and directed by the treating physician or other qualified health care professional.
    - Previously had to accumulate at least 60 minutes of service time
  - Part of CoCM services (Psychiatric Collaborative Care Model)
  - Used for either the initial month or subsequent months
  - Requirements for CPT 99493 apply
  - wRVU = 0.77

# 2021 Final Rule – Summary of Changes

**Additional Significant Changes** (continued)

- Maintained vaccine administration reimbursements at 2019 levels
- Electronic prescribing of controlled substances
  - Requirement to be implemented CY2021
  - Compliance will be monitored CY2022
  - Ten states currently require
  - 16 states have effective dates in 2021
- Rebased and revised FQHC Market Basket
  - Reflect 2017 base year
  - Market basket increase of 2.5%
  - Multifactor productivity adjustment of 0.6%
- Clinical Laboratory Fee Schedule (CLGS)
  - Payment decreases delayed – as permitted in the CARES Act

# 2021 Final Rule – Summary of Changes

**Additional Significant Changes** (continued)

- Appropriate Use Criteria (AUC)
  - Separately announced (8/10) extension of educational and testing period through 2021
    - No payment consequences until at least 2022
  - 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

# 2021 Final Rule – Summary of Changes

**Additional Significant Changes** (continued)

- Appropriate Use Criteria (AUC) (continued)
  - 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

# 2021 Final Rule – Summary of Changes

**Additional Significant Changes** (continued)

- Appropriate Use Criteria (AUC) (continued)
  - 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

# 2021 Final 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 30$^{th}$ percentile for 2021 and 2022
    - Increases to 40$^{th}$ percentile in 2023
    - Estimates that 95% of ACOs would achieve that score (based on 2018 data)

# E/M Coding Documentation

# E/M Coding Changes

- CMS Goal
  - To further ongoing effort to reduce administrative burden, improve payment accuracy, and update the Office/Outpatient (O/O) E/M visit code set to better reflect the current practice of medicine
- Maintained the 2020 Final Rule re: coding and reimbursement of E/M office/outpatient visits – 99201-99205; 99211-99215
  - 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 (MDM) or total time dedicated to patient encounter on day of service
    - Revising the times and medical decision-making process for these codes
      - Historic coding curves will likely shift
    - Requiring performance of history and examination only as medical appropriate –
      - No longer be the code-defining criteria as for 1995 and 1997 guidelines
  - **Documentation requirements for all other codes remain unchanged**

# Total Time

# E/M Coding Criteria – *Total Time*

- Code based on amount of total time **provider** dedicated to patient on day of service
  - Total time applies to the following on the **day of service only** …
    - 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
  - Time spent previously only applicable to these codes if greater than 50% of the face-to-face patient encounter was spent on counseling and/or education and/or care coordination

# E/M Coding Criteria – *Total Time*

- Total time parameters
  - CMS revised times per E/M code
    - Adjusted total time required to achieve most codes based on AMA RUC recommendations
      - "Finalized" times greater for most codes
    - However, implemented time ranges instead of single threshold times which are more practical in application
      - Not entirely consistent with "finalized" thresholds
    - May result in altered coding level for same amount of time previously expended

# E/M Coding Criteria – *Total Time*

| E/M Code | Current Total Time | CY2021 Total Time [a] | CY2021 Final Time Ranges [b] |
|---|---|---|---|
| 99201 | 17 | N/A | N/A |
| 99202 | 22 | 22 | 15 – 29 |
| 99203 | 29 | 40 | 30 – 44 |
| 99204 | 45 | 60 | 45 – 59 |
| 99205 | 67 | 85 | 60 – 74 |
| 99211 | 7 | 7 | N/A |
| 99212 | 16 | 18 | 10 – 19 |
| 99213 | 23 | 30 | 20 – 29 |
| 99214 | 40 | 47 | 30 – 39 |
| 99215 | 55 | 70 | 40 – 54 |

a. Table 20 of Final Rule
b. AMA CPT 2021 Professional Edition cited in several sources

# E/M Coding Criteria – *Total Time*

- Created new code related to Prolonged Services
  - G2212 replaces 99417 (99XXX in proposed rule)
  - Only applies when maximum times for 99205 and 99215 are exceeded by 15-minute increments
  - Listed in addition to the 99205 or 99215 codes

| E/M code(s) | Total Time Required |
|---|---|
| 99205 | 60-74 minutes |
| 99205 x 1 and G2212 x 1 | 89-103 minutes |
| 99205 x 1 and G2212 x 2 | 104-118 minutes |
| 99205 x 1; G2212 x 3 or more for each additional 15 minutes | 119 or more minutes |

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# E/M Coding Criteria – *Total Time*

- Created new code related to Prolonged Services (continued)

| E/M code(s) | Total Time Required |
|---|---|
| 99215 | 40-54 minutes |
| 99215 x1 and G2212 x1 | 69-83 minutes |
| 99215 x1 and G2212 x2 | 84-98 minutes |
| 99215 x 1; G2212 x 3 or more for each additional 15 minutes | 99 or more minutes |

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# E/M Coding Criteria – *Total Time*

- Threshold for considering use of total time may relate to ability to adequately capture time spent as better indicator of effort expended compared to MDM criteria
- Must be able to capture/document time spent on patient care activities and include total time in medical record documentation
  - Time logs? (similar to an attorney)
  - Auditable?

| Activity | Time (minutes) | Source |
|---|---|---|
| Pre-visit planning, chart review | 10 | Tracked in EHR |
| Face-to-Face encounter duration | 15 | Tracked in EHR |
| Phone call with daughter after visit | 10 | Tracked in phone |
| Encounter note completion | 10 | Tracked in EHR |
| **Total Time** | 45 | Entered in note |
| | (99215) | |

Adapted from S.L. Church, Tips for using total time to code E/M office visits in 2021. family Practice Management, Blogs, November 23, 2020.

# E/M Coding Criteria – *Total Time*

- May precipitate re-evaluation of workflow
  - Medical record review day before encounter
  - Medical record completion after the day of service
    - Though now "pays" for "pajama time" for medical record completion if accomplished on the day of service
  - Interfacing with family, consultants after the day of service
- Somewhat antithetical to the axiom –
  - Doing as much work that can be accomplished before the day of service allows the day of service to flow more efficiently and with less "surprises"

# Medical Decision-Making

# E/M Coding Criteria – *Medical Decision-Making*

- New criteria applied to Medical Decision-Making (MDM) as basis for E/M code assignment
- Absolute history and examination requirements that were a hallmark of the 1995 and 1997 coding criteria were eliminated
  - Replaced with encounter-appropriate history and examination requirement
- MDM always part of the 1995 and 1997 coding criteria, but EMR documentation templates focused heavily on 1995 and 1997 criteria related to inclusion of history and physical examination components
  - EMR documentation historically light on differential diagnosis / decision-making 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

# E/M Coding Criteria – *Medical Decision-Making*

- 2021 Medical Decision-Making elements
  - Number and complexity of **problems** addressed in the encounter
    - Only those evaluated or pertinent to the encounter
      - Not total number on Problem List
  - Amount and/or complexity of **data** reviewed and analyzed
    - Each unique test, order, or document reviewed for/in/after visit
      - Note that ordering or reviewing a CMP is a single unique test … each individual test in the panel is not counted
      - Independent interpretation of results is actually reviewing and providing an interpretation … not just reviewing a report
        - Cannot be included in E/M is billing separately for interpretation
  - **Risk** of complications and/or morbidity or mortality of patient management
- Encounter E/M level determined by the highest level achieved with at least two of the three elements
- Same criteria applied to "New" and "Established" patients

# 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*

AMA AMERICAN MEDICAL ASSOCIATION

| 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<br>**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<br>99212 | Straightforward | **Minimal**<br>• 1 self-limited or minor problem | **Minimal or none** | **Minimal risk of morbidity from additional diagnostic testing or treatment** |
| 99203<br>99213 | Low | **Low**<br>• 2 or more self-limited or minor problems;<br>**or**<br>• 1 stable chronic illness;<br>**or**<br>• 1 acute, uncomplicated illness or injury | **Limited**<br>*(Must meet the requirements of at least 1 of the 2 categories)*<br>**Category 1: Tests and documents**<br>• **Any combination of 2 from the following:**<br>  ▪ Review of prior external note(s) from each unique source*;<br>  ▪ review of the result(s) of each unique test*;<br>  ▪ ordering of each unique test*<br>**or**<br>**Category 2: Assessment requiring an independent historian(s)**<br>*(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<br>99214 | Moderate | **Moderate**<br>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment;<br>**or**<br>• 2 or more stable chronic illnesses;<br>**or**<br>• 1 undiagnosed new problem with uncertain prognosis;<br>**or**<br>• 1 acute illness with systemic symptoms;<br>**or**<br>• 1 acute complicated injury | **Moderate**<br>*(Must meet the requirements of at least 1 out of 3 categories)*<br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following:**<br>  ▪ Review of prior external note(s) from each unique source*;<br>  ▪ Review of the result(s) of each unique test*;<br>  ▪ Ordering of each unique test*;<br>  ▪ Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• 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**<br>*Examples only:*<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |
| 99205<br>99215 | High | **High**<br>• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment;<br>**or**<br>• 1 acute or chronic illness or injury that poses a threat to life or bodily function | **Extensive**<br>*(Must meet the requirements of at least 2 out of 3 categories)*<br>**Category 1: Tests, documents, or independent historian(s)**<br>• **Any combination of 3 from the following:**<br>  ▪ Review of prior external note(s) from each unique source*;<br>  ▪ Review of the result(s) of each unique test*;<br>  ▪ Ordering of each unique test*;<br>  ▪ Assessment requiring an independent historian(s)<br>**or**<br>**Category 2: Independent interpretation of tests**<br>• **Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);**<br>**or**<br>**Category 3: Discussion of management or test interpretation**<br>• 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**<br>*Examples only:*<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• 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

# E/M Coding Criteria – *Medical Decision-Making*

- 2021 Medical Decision-Making elements – **Problems**

| Code | MDM Level | Description |
|---|---|---|
| 99202<br>99212 | Straightforward | Minimal<br>• 1 self-limited or minor problem |
| 99203<br>99213 | Low | Low<br>• 2 or more self-limited or minor problems; **or**<br>• 1 stable chronic illness; **or**<br>• 1 acute, uncomplicated illness or injury |
| 99204<br>99214 | Moderate | Moderate<br>• 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **or**<br>• 2 or more stable chronic illnesses; **or**<br>• 1 undiagnosed new problem with uncertain prognosis; **or**<br>• 1 acute illness with systemic symptoms; **or**<br>• 1 acute complicated injury |
| 99205<br>99215 | High | High<br>• 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **or**<br>• 1 acute or chronic illness or injury that poses a threat to life or bodily function |

# E/M Coding Criteria – *Medical Decision-Making*

- 2021 Medical Decision-Making elements – **Data**

| Code | MDM Level | Description |
|---|---|---|
| 99202<br>99212 | Straightforward | Minimal or none |
| 99203<br>99213 | Low | Limited (Must meet the requirements of at least 1 of the 2 categories)<br>Category 1: Tests and documents<br>Any combination of 2 from the following:<br>• Review prior external note(s) from each unique source*;<br>• Review the result(s) of each unique test*;<br>• Order each unique test*<br>**OR**<br>Category 2: Assessment requiring an independent historian(s)<br>(For the categories of independent interpretation of tests and discussion of management or test interpretation, see moderate or high) |

# E/M Coding Criteria – *Medical Decision-Making*

- 2021 Medical Decision-Making elements – **Data** (continued)

| Code | MDM Level | Description |
|---|---|---|
| 99204<br>99214 | Moderate | Moderate – (Must meet the requirements of at least 1 out of 3 categories)<br>Category 1: Tests, documents, or independent historian(s)<br>• Any combination of 3 from the following:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**OR**<br>Category 2: Independent interpretation of tests<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**OR**<br>Category 3: Discussion of management or test interpretation<br>• Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported) |

# E/M Coding Criteria – *Medical Decision-Making*

- 2021 Medical Decision-Making elements – **Data** (continued)

| Code | MDM Level | Description |
|---|---|---|
| 99205<br>99215 | High | Extensive – (Must meet the requirements of at least 2 out of 3 categories)<br>Category 1: Tests, documents, or independent historian(s)<br>• Any combination of 3 from the following:<br>  • Review of prior external note(s) from each unique source*;<br>  • Review of the result(s) of each unique test*;<br>  • Ordering of each unique test*;<br>  • Assessment requiring an independent historian(s)<br>**OR**<br>Category 2: Independent interpretation of tests<br>• Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported);<br>**OR**<br>Category 3: Discussion of management or test interpretation<br>• Discussion of management or test interpretation with external physician/other qualified health care professional/ appropriate source (not separately reported) |

# E/M Coding Criteria – *Medical Decision-Making*

- 2021 Medical Decision-Making elements – **Risk**

| Code | MDM Level | Description |
|---|---|---|
| 99202<br>99212 | Straightforward | Minimal risk of morbidity from additional diagnostic testing or treatment |
| 99203<br>99213 | Low | Low risk of morbidity from additional diagnostic testing or treatment |
| 99204<br>99214 | Moderate | Moderate risk of morbidity from additional diagnostic testing or treatment<br>*Examples only*:<br>• Prescription drug management<br>• Decision regarding minor surgery with identified patient or procedure risk factors<br>• Decision regarding elective major surgery without identified<br>• patient or procedure risk factors<br>• Diagnosis or treatment significantly limited by social determinants of health |

# E/M Coding Criteria – *Medical Decision-Making*

- 2021 Medical Decision-Making elements – **Risk** (continued)

| Code | MDM Level | Description |
|---|---|---|
| 99205<br>99215 | High | High risk of morbidity from additional diagnostic testing or treatment<br>*Examples only*:<br>• Drug therapy requiring intensive monitoring for toxicity<br>• Decision regarding elective major surgery with identified patient or procedure risk factors<br>• Decision regarding emergency major surgery<br>• Decision regarding hospitalization<br>• Decision not to resuscitate or to de-escalate care because of poor prognosis |

# E/M Coding Criteria – *Medical Decision-Making*

- Clarified and changed code related to office/outpatient E/M visit complexity
  - G2211 replaces GPC1X
    - Earns additional wRVU credit of 0.33
  - Intended to reward "the time, intensity, and [expense] involved in furnishing services to patients on an ongoing basis that result in a comprehensive, longitudinal, and continuous relationship with the patient and involves delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape, [that] are not adequately described by the revised office/outpatient E/M visit code set."
  - Adds additional wRVU credit for visit complexity associated with patient's single, serious, or complex condition
  - Can be used for New or Established patients
  - Can be used with any O/O E/M code
  - Likely to be used with every of O/O E/M visits by specialties that rely on O/O E/M visits to report the majority of their services

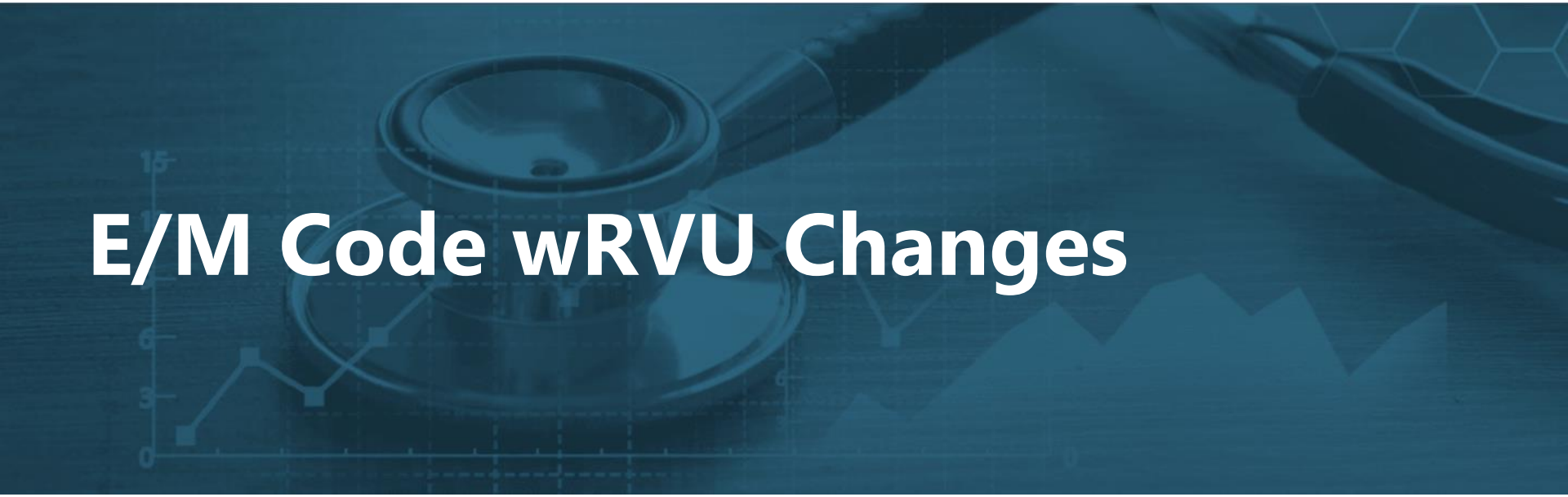
# E/M Coding Criteria – *Medical Decision-Making*

- Example where appropriate to use G2211 (Final Rule page 278)
  - Visit of "a 68 year-old woman with progressive congestive heart failure (CHF), diabetes, and gout, on multiple medications, who presents to her physician for an established patient visit. The clinician discusses the patient's current health issues, which includes confirmation that her CHF symptoms have remained stable over the past 3 months. She also denies symptoms to suggest hyper- or hypoglycemia, but does note ongoing pain in her right wrist and knee. The clinician adjusts the dosage of some of the patient's medications, instructs the patient to take acetaminophen for her joint pain, and orders laboratory tests to assess glycemic control, metabolic status, and kidney function. The practitioner also discusses age appropriate prevention with the patient and orders a pneumonia vaccination and screening colonoscopy. In this clinical example, the practitioner is serving as a focal point for the patient's care, addressing the broad scope of the patient's health care needs, by furnishing care for some or all of the patient's conditions across a spectrum of diagnoses and organ systems with consistency and continuity over time."

# E/M Coding Criteria – *Medical Decision-Making*

- Example where ***not*** appropriate to use G2211 (Final Rule page 279)
  - When the care "furnished during the office/outpatient E/M visit is provided by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature, such as
    - A mole removal or referral to a physician for removal of a mole
    - Treatment of a simple virus
    - Counseling related to seasonal allergies
    - Initial onset gastroesophageal reflux disease
    - Treatment for a fracture

    where comorbidities are either not present or not addressed, and/or and when the billing practitioner has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity over time, or does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time."



# E/M Code wRVU Changes

# E/M Code wRVU Changes

- 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

# E/M Code wRVU Changes – Direct

| E/M Code | Current wRVU | CY2021 wRVU | Percent Increase |
|---|---|---|---|
| 99201 | 0.48 | N/A | N/A |
| 99202 | 0.93 | 0.93 | 0% |
| 99203 | 1.42 | 1.6 | 13% |
| 99204 | 2.43 | 2.6 | 7% |
| 99205 | 3.17 | 3.5 | 10% |
| 99211 | 0.18 | 0.18 | 0% |
| 99212 | 0.48 | 0.7 | 46% |
| 99213 | 0.97 | 1.3 | 34% |
| 99214 | 1.5 | 1.92 | 28% |
| 99215 | 2.11 | 2.8 | 33% |
| G2212 (Prolonged) | N/A | 0.61 | N/A |
| G2211 (Complexity) | N/A | 0.33 | N/A |

Adapted from Table 20 Final Rule

# E/M Code wRVU Changes – *Indirect Trickle-Down Effect*

- Value of the codes associated with following services will increase in 2021 as a result of the above changes since based in part on those E/M codes
  - 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
- Review of potentially "misvalued" services codes
  - CMS indicated significant impact across specialties

# E/M Code wRVU Changes – By Specialty

- Anticipated impact of the Final Rule on wRVUs by specialty based on comparison of the 2020 and 2021 Medicare Provider Utilization and Payment Databases
- Impact ranges from -1% to +21%

| Percent Change | Number of Specialties | Percent of Specialties |
|---|---|---|
| Negative | 1 | 2% |
| 0% | 5 | 8% |
| Less than 5% | 8 | 13% |
| 5-9% | 19 | 30% |
| 10-14% | 17 | 27% |
| 15% or greater | 13 | 21% |
| **Totals** | 63 | 101% |

# E/M Code wRVU Changes – By Specialty

| Specialty | |
|---|---|
| Rheumatology | 22% |
| Endocrinology | 21% |
| Hematology/Oncology | 19% |
| Family Practice | 19% |
| Allergy/Immunology | 18% |
| OB/GYN | 16% |
| Nephrology | 16% |
| Urology | 15% |
| ENT | 14% |
| Pediatrics | 14% |
| Psychiatry | 12% |
| Neurology | 12% |
| Interventional Pain Management | 13% |

| Specialty | |
|---|---|
| Internal Medicine | 11% |
| Podiatry | 11% |
| Dermatology | 10% |
| Cardiology | 9% |
| Pulmonology | 7% |
| Orthopedic Surgery | 7% |
| PM&R | 7% |
| General Surgery | 6% |
| Vascular Surgery | 6% |
| Plastic Surgery | 6% |
| Gastroenterology | 6% |
| Neurosurgery | 5% |
| Infectious Disease | 3% |

# E/M Code wRVU Changes – By Specialty

## Neutral

| Specialty | |
|---|---|
| Critical Care | 2% |
| Cardiac Surgery | 2% |
| Thoracic Surgery | 2% |
| Radiation Oncology | 2% |
| Hospital Medicine | 0% |
| Medical Genetics/Genomics | 0% |
| Interventional Radiology | 0% |
| Chiropractic | 0% |
| Diagnostic Radiology | -1% |

# 2021 Conversion Factor

# 2021 Conversion Factor

- Required to maintain budget neutrality when changes in wRVUs made
- 2021 Conversion Factor will be $32.41
  - Compared to 2020 rate of $36.09
  - Absolute decrease of $3.68 or 10.2%
  - Recent consistency year to year
    - Compared to 2019 rate of $36.04
    - Compared to 2018 rate of $35.99
- Impact will not be recovered through QPP incentives
  - MIPS less than 2%
  - Advanced APM 5%
- Impact will not be uniform across specialties

# 2021 Conversion Factor

- AMA, MGMA, and many other professional societies indicate(d) opposition to this degree of decrease in a single year – especially coincident with the adverse financial impact of COVID-19
  - During the public comment period, a number of options were proposed including waiver of budget neutrality, delayed implementation to allow for adjustment interval, or phased implementation approach to the changes
  - Now appealing to Congress for relief

# 2021 MPFS Final Rule – Reimbursement Impact

# 2021 Medicare Reimbursement Impact – *By Specialty*

- CMS provided a mechanism to predict the impact of the 2021 MPFS Final Rule changes on revenues by specialty
- The Table 106 Total RVU column lists percentage changes of **Total Allowed Charges** for 55 specialties

  *IF* the historically rendered/ claimed national service mix *and* the historic national coding curves do not change

- The impact of Payment Year 2021 (based on 2019 performance data) Quality Payment Program (QPP … MIPS, Advanced APM paths) adjustments must separately be factored in
- The 2021 Final Rule impact on **Total Allowed Charges** ranges from -10% to +16%

Table 106 of Final Rule

# 2021 Medicare Reimbursement Impact – *By Specialty*

| **Positive** | |
|---|---|
| Endocrinology | 16% |
| Hem/Onc | 14% |
| Family Practice | 13% |
| Allergy | 9% |
| Urology | 8% |
| OB/GYN | 7% |
| ENT | 7% |
| Psychiatry | 7% |
| Neurology | 6% |
| Nephrology | 6% |
| Pediatrics | 6% |
| Internal Medicine | 4% |

| **Neutral** | |
|---|---|
| Clinical Psychology | 0% |
| Clinical Social Work | 1% |
| Cardiology | 1% |
| Pulmonology | 1% |
| Podiatry | -1% |
| Dermatology | -1% |

| **Negative** | |
|---|---|
| Radiology | -10% |
| CRNA | -10% |
| Chiropractic | -10% |
| Interventional Radiology | -8% |
| Cardiac Surgery | -8% |
| Thoracic Surgery | -8% |
| Anesthesiology | -8% |
| Plastic Surgery | -7% |
| Vascular Surgery | -6% |
| General Surgery | -6% |
| Neurosurgery | -6% |
| Gastroenterology | -4% |
| Orthopedic Surgery | -4% |

Adapted from Table 106 of Final Rule

# 2021 Medicare Reimbursement Impact – *By Specialty*

**Positive Impact – Total Allowed Charges**

| Percent Change | Number of Specialties | Percent of Specialties |
|---|---|---|
| Less than 5% | 5 | 9% |
| 5-9% | 12 | 22% |
| 10-14% | 2 | 4% |
| 15% or greater | 2 | 4% |
| **Totals** | 21 | 38% |

Adapted from Table 106 of Final Rule

# 2021 Medicare Reimbursement Impact – *By Specialty*

**Negative Impact – Total Allowed Charges**

| Percent Change | Number of Specialties | Percent of Specialties |
|---|---|---|
| Less than 5% | 11 | 20% |
| 5-9% | 20 | 36% |
| 10-14% | 3 | 6% |
| 15% or greater | 0 | 0% |
| **Totals** | 34 | 62% |

Adapted from Table 106 of Final Rule

# 2021 MPFS Final Rule – Provider Compensation Impact

# 2021 Provider Compensation Impact

- Potential impact of the 2021 MPFS Final Rule on provider compensation will depend on
  - Type of provider compensation model
  - Impact of documentation changes on individual historic coding patterns
- Actual impact will be organization/individual-specific depending on
  - Provider contract latitude
  - Whether compensation rates are tethered to the Medicare Conversion Factor
  - Whether organization feels prudent to try to accurately predict the actual impact of the changes precipitated by the Final Rule
    - Coding pattern changes based on new documentation requirements
    - Levels of wRVU credits generated according to the prevalence of affected CPTs submitted for claims
    - Affordability due to corresponding changes in anticipated Medicare revenues

# 2021 Provider Compensation Impact

- Type of Provider Compensation Model
  - Straight Salary Model – No Change anticipated
    - Major impact of the Final Rule will be related to the changes in reimbursement revenues and affordability
  - Straight wRVU Model – Will change by specialty consistent with credited wRVU levels and relative utilization of CPT codes with changes
  - Revenue-Expense Model – Will be based on reimbursement/revenue changes driven by the decrease in conversion factor offset by any increases or decreases in Total RVU Allowable Charges
  - Base plus Incentives Model – Will be impacted to degree dependent on CPT codes with impacted wRVUs


HSG | Thank You

# Company **Overview**

## HSG builds high-performing physician networks so health systems can address complex changes with confidence.

**Headquarters:** Louisville, KY

**Formed:** 1999

**Focus:** Health Systems and Physician Network Strategy and Execution

### Physician Strategy

Driving a common strategic focus with engaged physicians.

### Physician Leadership

Identifying and engaging strong physician leaders is integral to the network's development and success.

### Performance Improvement

Improving the performance of employed physician networks.

### Network Integrity

Leveraging Physician Network Integrity Analytics™ to create and monitor strategies for patient acquisition and retention.

### Physician Compensation

Aligning physician compensation with health system and employed network goals.

# HSG **Services**

HSG builds high-performing physician networks so health systems can address complex changes with confidence.

## Physician Strategy

Healthcare System Strategic Plans

Employed Physician Network Strategy

Growth Strategy

Shared Vision and Culture Development

Physician Manpower Plans

Service Line Strategy

Co-Management

## Physician Leadership

Shared Vision and Culture

Physician Burnout

Physician Governance and Leadership

## Performance Improvement

Network Performance Improvement

Performance Improvement Implementation

Network Revenue Cycle

Practice Care Model Transformation

Practice Acquisition

Advanced Practice (APP) Utilization

Virtual Health

## Network Integrity

Patient Share of Care

Patient Flow

Provider Location and Service Analysis

Market Insights

## Physician Compensation

Compensation Plan Design

Fair Market Value and Commercial Reasonableness Opinions

Advanced Practice Provider (APP) Compensation