Illinois Health and Hospital Association

MEDICARE PAYMENT FACT SHEET

DECEMBER 2020

CY 2021 MEDICARE PHYSICIAN FEE SCHEDULE FINAL RULE – CMS-1734-F

On Dec. 1, the Centers for Medicare & Medicaid Services (CMS) released its annual final rule updating the Medicare Physician Fee Schedule (PFS) effective Jan. 1 through Dec. 31, 2021. This final rule, not yet published in the *Federal Register*, includes several changes related to telehealth services, Medicare Part B payment policies, various Medicare quality programs, the Medicare Diabetes Prevention Program (MDPP), and finalization of certain provisions of the interim final rules issued by CMS on Mar. 31, May 8, and Sept. 2 in response the COVID-19 public health emergency (PHE).

CY 2021 PFS Conversion Factor: The final CY 2021 PFS conversion factor is $32.41, a decrease of $3.68 compared to CY 2020. This represents a net decrease in the conversion factors of 10.2% in CY 2021.

Telehealth: CMS assigned telehealth services that have been proposed or requested for Medicare reimbursement into the following three categories, which distinguish temporary and permanent changes.

Telehealth Service Categories

Service Category	Service Category Description
Category 1	Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on the list of telehealth services.
Category 2	Services that are not similar to the current list of telehealth services.
Category 3	Services added to the Medicare telehealth list during the public health emergency (PHE) for the COVID-19 pandemic **that will remain on the list through the calendar year in which the PHE ends**.

For CY 2021, CMS added a series of Category 1 and 3 services, but none that are dissimilar to the current list of reimbursed telehealth services on a permanent basis (Category 2). The following is a summary of the new additions for service reimbursement.

CY 2021 Category 1 Telehealth Services

Service Type	HCPCS/CPT Code
Group Psychotherapy	CPT code 90853
Psychological and Neuropsychological Testing	CPT code 96121
Domiciliary, Rest Home, or Custodial Care services, Established patients	CPT codes 99334-99335
Home Visits, Established Patient	CPT codes 99347-99348
Cognitive Assessment and Care Planning Services	CPT code 99483
Visit Complexity Inherent to Certain Office/Outpatient Evaluation and Management (E/M)	HCPCS code G2211
Prolonged Services	HCPCS code G2212

CY 2021 Category 3 Telehealth Services

Service Type	HCPCS/CPT Code
Domiciliary, Rest Home, or Custodial Care services, Established patients	CPT codes 99336-99337
Home Visits, Established Patient	CPT codes 99349-99350
Emergency Department Visits, Levels 1-5	CPT codes 99281-99285
Nursing facilities discharge day management	CPT codes 99315-99316
Psychological and Neuropsychological Testing	CPT codes 96130-96133; CPT codes 96136-96139
Therapy Services, Physical and Occupational Therapy, All levels	CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507
Hospital discharge day management	CPT codes 99238-99239
Inpatient Neonatal and Pediatric Critical Care, Subsequent	CPT codes 99469, 99472, 99476
Continuing Neonatal Intensive Care Services	CPT codes 99478-99480
Critical Care Services	CPT codes 99291-99292
End-Stage Renal Disease Monthly Capitation Payment codes	CPT codes 90952, 90953, 90956, 90959, 90962
Subsequent Observation and Observation Discharge Day Management	CPT codes 99217; CPT codes 99224-99226

Other changes and clarifications include:

- Revised frequency limitation of subsequent nursing facility (NF) visits from one visit every 30 days to once every 14 days.
    - Background: CMS originally proposed shifting the limitation to once every 3 days, but reconsidered due to a potential disincentive for in-person care. The agency also recognized that NF stays are longer than inpatient hospital stays, but the proposed frequency limitation would have aligned with inpatient care. CMS seeks comment on whether removing the limitation completely would be appropriate.
- Additions to the list of non-physician practitioners that may seek reimbursement for brief online assessment and management services, virtual check-ins, and remote evaluation services.
    - Background: To facilitate billing for the remote evaluation of patient-submitted video or images and virtual check-ins by licensed clinical social workers, clinical psychologists, physical therapists, occupational therapists, and speech-language pathologists, two new HCPCS G-codes have been established (G2010 and G2012).
- Telehealth rules do not apply when the beneficiary and the practitioner are in the same location even if audio/video technology assists in furnishing a service.
    - Background: A common example is when a physician furnishing a service and the patient are in the same hospital, but using telecommunications technology due to exposure risks.
- A new HCPCS G-code (G2252) describing 11-20 minutes of medical discussion to determine the necessity of an in-person visit establishing payment on an interim final basis, based on commenter support for audio-only telephone evaluation and management (E/M) services.

- For newly finalized services involving home visits, the home can only be billed as an originating site for treatment of a substance use disorder or a co-occurring mental health disorder.
    - Background: While a patient's home is not an approved originating site in general, the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities Act authorizes a patient's home as an originating site specifically for the aforementioned services.
- For remote physiologic monitoring (RPM) services, providers may now obtain patient consent at the time services are furnished. Auxiliary personnel, including contracted employees, may furnish RPM services (CPT codes 99453 and 99454) under general supervision of the billing practitioner. Following CY 2021, CMS will not allow providers to furnish RPM services to new patients (only established patients) and will commence billing requirements for 16 days of data submitted within 30 days for CPT codes 99453 and 99454. These services may be medically necessary and furnished for patients with acute conditions in addition to chronic conditions. Any medical device supplied to a patient must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act, meaning the device must be reliable and valid, and the data must be automatically collected electronically and transmitted, rather than self-reported.
    - Background: RPM has been extended to new patients and billing requirements were relaxed for the PHE, but these policies are clarified to be temporary.

Direct Supervision via Interactive Telecommunications Technology: In response to the COVID-19 PHE, CMS expanded the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology. This definition of direct supervision will remain in place through the later of (1) the end of the calendar year in which the PHE ends, or (2) Dec. 31, 2021.

Interim Final Rule for Coding and Payment for Personal Protective Equipment (PPE) (CPT code 99072): Since the publication of the CY 2021 PFS proposed rule, the CPT Editorial Panel created CPT code 99072: *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other no-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease*. CMS finalized this CPT code as a bundled service on an interim basis. CMS also finalized several supply-pricing increases on an interim basis, including N95 masks (supply code SD344), surgical masks (SB033), and surgical mask with face shield (SB034). CMS waived the notice of proposed rulemaking for CPT code 99072, though the public does have 60 days to submit comments on this interim final rule.

Evaluation and Management Coding and Payment: CMS changed its office/outpatient E/M coding, documentation, and payment policies to align with changes adopted in the CY 2020 PFS final rule.

CMS also revalued several code sets to reflect valuation increases finalized in previous PFS final rules for office/outpatient E/M visits, including:

- End-Stage Renal Disease (ESRD) Monthly Capitation Payment Services;

- Transitional Care Management Services;
- Maternity Services;
- Cognitive Impairment Assessment and Care Planning;
- Initial Preventive Physical Examination and Initial and Subsequent Annual Wellness Visits;
- Emergency Department Visits;
- Therapy Evaluations; and
- Psychiatric Diagnostic Evaluations and Psychotherapy Services.

CMS provides a detailed methodological overview for finalized revaluations in the final rule.

Payment for Services of Teaching Physicians and Resident "Moonlighting" Services: CMS will allow teaching physicians to use interactive, real-time audio/video technology to supervise and interact with residents training at sites in rural areas. The medical record must clearly reflect how the teaching physician was present to the resident during the service, and does not apply to surgical, high risk, interventional, or other complex procedures.

Additionally, CMS permanently expanded the settings in which residents may moonlight. Such settings now include the services of residents unrelated to their approved Graduate Medical Education (GME) programs and furnished to inpatients of a hospital in which they have their training program. The medical record must show that:

1. The resident furnished identifiable physician services that meet the conditions of payment for physician services to beneficiaries in providers (e.g., provision of physician services in hospitals);
2. The resident is fully licensed to practice medicine, osteopathy, dentistry or podiatry by the State in which the services are performed; and
3. The services are not performed as part of the approve GME program.

Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs): CMS finalized the proposal to extend the definition of OUD treatment services to include opioid antagonist medications (i.e., naloxone) approved by the U.S. Food and Drug Administration for emergency treatment of opioid overdose. CMS also finalized two new add-on codes. The first covers the cost of providing nasal naloxone and setting the payment amount at average sales price (ASP) + 0. The second covers injectable naloxone and sets the price at contractor pricing for CY 2021. CMS limited codes describing naloxone to one add-on code every 30 days, with an exception for cases where the beneficiary overdoses and uses the supply of naloxone given to them by the OTP when medically reasonable and necessary.

Removal of Six National Coverage Determinations (NCDs): CMS removed six outdated NCDs, meaning Medicare Administrative Contractors (MACs) are no longer required to follow these specific coverage policies. The removed NCDs include:

NCD Manual Citation	Name of NCD
20.5	Extracorporeal Immunoadsorption (ECI) Using Protein A Columns
30.4	Electrosleep Therapy
100.9	Implantation of Gastrointestinal Reflux Devices

110.19	Abarelix for the Treatment of Prostate Cancer
220.2.1	Magnetic Resonance Spectroscopy
220.6.16	FDG PET for Inflammation and Infection

The implementing change request will take time discrepancies between the effective and implementation dates into consideration to ensure appropriate adjudication of claims retroactive to the effective date of the CY 2021 PFS final rule.

CY 2021 Quality Payment Program: There are two reporting frameworks available for the 2021 performance period: the traditional Merit-based Incentive Payment System (MIPS) and the Alternative Payment Model (APM) Performance Pathway (APP). CMS intends to add the first MIPS Value Pathways (MVPs) for the 2022 performance period. CMS forewent implementing specific MVPs in CY 2021 due to the ongoing COVID-19 PHE.

CMS did finalize the MVPs guiding principles, including the patient voice, subgroup reporting, and data measure involving promoting digital performance. CMS also finalized a set of criteria for consideration when creating MVP candidates for the 2022 and future performance periods.

For the CY 2021 MIPS performance period, CMS will lower the weight of the quality category to 40% and raise the weight of the cost category to 20%.

Regarding the APP, CMS finalized a new 2021 reporting framework that compliments MVPs. CMS extended the use of the CMS Web Interface as a collection type for MIPS during the 2021 performance period, with a plan to sunset the CMS Web Interface beginning with the 2022 performance period. CMS also finalized the APP quality measure set, and determined that quality scores for Accountable Care Organizations (ACOs) reported through the APP will also satisfy reporting requirements for the Medicare Shared Savings Program.

To recognize the impact of COVID-19 on the 2020 performance year, CMS will double the number of points available for the complex patient bonus to account for the additional complexity of treating patients during the PHE. Clinicians, groups, virtual groups, and APM entities can now earn up to 10 bonus points toward their final score for the 2020 performance period. Additionally, beginning with the 2020 performance period, CMS will allow APM Entities to submit an application to reweight MIPS performance categories due to extreme and uncontrollable circumstances, such as the COVID-19 PHE.

Finally, in light of the COVID-19 PHE, the Medicare Shared Savings Program extreme and uncontrollable circumstances policy applies to all ACOs for the 2020 performance year. CMS waived the requirement for ACOs to field a CAHPS for ACOs Survey, and all ACOs will receive automatic full credit for the patient experience of care measures. CMS also finalized revisions to the Medicare Shared Savings Program that begin in the 2021 performance year, aligning the program's quality reporting requirements with the requirements that will apply under the APP.

Additionally details on the CY 2021 Quality Payment Programs are here.

Medicare Diabetes Prevention Program (MDPP): The original intent of the MDPP was to provide primarily in-person services with the goal of preventing type 2 diabetes in individuals with an indication of prediabetes. The primary goal of the model is at least 5 percent weight loss by participants, achieved through a clinical intervention curriculum furnished over six months in

group-based, classroom-style settings. During the COVID-19 PHE, CMS provided flexibilities to MDPP beneficiaries and suppliers, allowing for virtual service delivery, waiver of weight loss eligibility requirements, and allowance for temporary suspension of the MDPP program for certain participants.

The changes made to the MDPP in the CY 2021 PFS final rule will remain in place for the remainder of the COVID-19 PHE and apply to any future applicable 1135 waiver event, as determined by CMS. These changes include, but are not limited to, the following:

- Allowing MDPP suppliers to deliver services virtually or suspend such services, resuming at a later date;
- Allowing MDPP beneficiaries that either start or switch to virtual services during the COVID-19 PHE or other applicable 1135 waiver event to continue receiving MDPP services virtually, even after the applicable event is over;
- Allowing beneficiaries that suspend MDPP services due to an applicable event to maintain MDPP eligibility despite a break in service;
- Allowing MDPP suppliers to collect weight measurements from beneficiaries via digital technology (i.e., Bluetooth™ enabled device) or self-reported weight measurements taken on a digital scale; and
- Allowing MDPP beneficiaries to use online video technology with an MDPP coach versus in-person coaching sessions.

Contact:

Contact IHA

Sources:

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