CY 2021 Medicare Physician Fee Schedule Proposed Rule (CMS-1734-P)

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INTRODUCTORY SUMMARY AND BACKGROUND

On August 4, 2020, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for the Medicare Physician Fee Schedule (MPFS) for CY 2021.

Since 1992, Medicare has paid for physician services under section 1848 of the Social Security Act entitled "Payment for Physicians' Services". This statute requires CMS to establish payments under the physician fee schedule (PFS) based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service.

The statute requires that RVUs be established for three categories of resources:

- Work **(Work)** – services the physician provides.
- Practice Expense **(PE)** – resources that are used to provide physician services, such as office overhead and staff salaries.
- Malpractice **(MP)** expense – costs involved in malpractice insurance.

In addition, the statute requires CMS establish by regulation each year's payment amounts for all physicians' services paid under the PFS, incorporating geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas. This is referred to as the geographic practice cost indices **(GPCIs)**.

RVUs are converted to dollar amounts through the application of the conversion factor **(CF)**. The formula for the calculating the MPFS is as follows:

Payment = [(RVU work x GPCI work) + (RVU PE x GPCI PE) + (RVU MP x GPCI MP)] x CF

MPFS Proposed Rule

The CY 2021 proposed rule is located in its entirety at the following link:
https://s3.amazonaws.com/public-inspection.federalregister.gov/2020-17127.pdf

This document in PDF form is 1,353 pages in length. The format of the information is intended to summarize the proposed changes so readers are encouraged to view the document in its entirety for further details.

PROPOSED CHANGES TO MPFS PAYMENT RATES

Conversion Factor (CF)

Section 1848 of the Act requires CMS to maintain the budget within $20 million annually. In the event it is projected to exceed this amount, budget neutrality adjustments are made. In the CY 2021 proposed rule, the CF is based on a minus 10.61 percent adjustment, which results in a CF of $32.2605.

TABLE 88: Calculation of the CY 2021 PFS Conversion Factor

CY 2021 Conversion Factor		36.0896
Statutory Update Factor	0.00 percent (1.0000)	
CY 2021 RVU Budget Neutrality Adjustment	-10.61 percent (0.8939)	
CY 2021 Conversion Factor		**32.2605**

To calculate the CY 2021 CF, the product of the current year CF and the update adjustment factor was multiplied by the budget neutrality adjustment. As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the CF was frozen at CY 2020 value with no increase for the next five years. The CY 2020 CF is $36.0896 and this value is used for CY2021 with direct adjustment.

Changes in RVUs

The significant CF decrease is not proposed to impact all specialties equally. Impacts to the CF are related to changes associated to misvalued codes; phasing in the Direct Practice Expense equipment value changes; and increases in valuation for evaluation and management (E/M) services. To account for increases impacting some specialties, monies must be reallocated from other specialties to cover and maintain budget neutrality.

Table 90 outlines the combined payment impact per specialties including cardiac surgery, interventional radiology and vascular surgery pertaining to the proposed RUV changes for CY 2021:

TABLE 90: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F)* Combined Impact
Cardiac Surgery	$264	-6%	-2%	-1%	-9%
Interventional Radiology	$497	-3%	-5%	0%	-9%
Vascular Surgery	$1,287	-2%	-5%	0%	-7%

* Column F may not equal the sum of columns C, D, and E due to rounding.

The estimated impacts for other specialties including cardiac surgery reflect decreased payments as a result of relative to payment to other physician specialties which are largely the result of the redistributive effects of previously finalized changes to the office/outpatient E/M visits taking effect in 2021. These estimations also reflect implementation of: (1) finalized updates to supply and equipment pricing; and (2) finalized code-level reductions that continue to be phased-in over several years.

Work RVUs

Work RVUs are established for new, revised and potentially misvalued codes based on portion of resources used in furnishing the service that reflects physician time and intensity.

Practice Expense RVUs (PE)

PE RVUs are developed by reviewing practice resources involved in providing each service and are comprised of direct and indirect PE. For direct PE (clinical staff, medical supplies, medical equipment), these costs are calculated based on inputs from the CMS PE database, generally centered on recommendations of the Relative Value Scale Update Committee (RUC). Indirect PE costs are developed primarily on the Physician Practice Expense Information Survey (PPIS). Implemented in CY 2010, the PPIS is a multispecialty, nationally representative, PE survey of both physicians and NPPs paid under the PFS.

For procedures provided in a physician's office or facility setting in which Medicare makes a separate payment to the facility, CMS establishes 2 PE RVUs: facility and nonfacility. In calculating PE RUVs for physician services provided in a facility, resources not typically utilized by physicians while providing services are excluded. Thus, facility PE RVUs are typically lower than nonfacility PE RUVs.

Diagnostic services are generally comprised of a professional component (PC); and a technical component (TC). The PC and TC may be furnished independently, by different providers, or together as a global service. Each component has separate reimbursement; however, payment for the global service equals the sum of the payment for TC and PC. This is based on a weighted average of the ratio of direct to indirect costs across all specialties that provide the global service.

Malpractice RVUs (MP)

MP RVUs are considered to be resourced based, and required to be reviewed annually to more accurately represent and evaluate mix of practitioners providing services on Medicare claims. There are three factors which are considered to determine MP RVUs for PFS services:

1) Specialty-level risk factors derived from data on specialty-specific MP premiums incurred by practitioners;
2) Service-level risk factors derived from Medicare claims data of the weighted average risk factors of the specialties that furnish each service; and
3) Intensity/complexity of service adjustment to the service level risk factor based on either the higher of the work RVU or clinical labor RVU.

Prior to CY 2016, MP RVUs were updated every 5 years unless there were new or revised codes introduced. MP GPCI is currently reviewed every three years. The CY 2016 MPFS final rule implemented the policy to review MP RVUs annually. The new policy also specifies use of 3 years' worth of data rather than 1 year.

For CY 2020, CMS finalized their proposal that the values of the MP RVUs and MP GPCI be coordinated because the MP premium data used to update the MP GPCI is the same to determine the risk levels of the specialties. This change would put the next review for implementation in CY 2023.

Geographic Practice Cost Indices (GPCIs)

CMS is required to develop separate GPCIs to measure cost differences among localities compared to the national average. CMS adjusts reimbursement to align with the cost of those services specific to where they were provided. This is done by applying the GPCI values for a specific area to each of the RVUs (work, practice expense, and malpractice). This is one of the reasons when discussing reimbursement, it is not always an apples-to-apples comparison with regard to how much is reimbursed from one location to another.

The current fee schedule areas are referred to as payment localities are defined by state boundaries; metropolitan areas; portions of a metropolitan area; or rest-of state areas. There are currently 112 payment localities. This locality configuration is used to calculate GPCIs that in turn are used to calculate locality adjusted payment for physicians under PFS.

Five states are defined as "frontier states" by CMS: Montana, Wyoming, North Dakota, South Dakota and Nevada. A frontier state is one in which at least 50 percent of the counties are "frontier counties" (counties that have a population per square mile of less than 6). This is significant because the cost of living can be relative to how populated an area might be. Thus, a less populated area could have less services and lower reimbursement. These frontier states have a PE GPCI floor of 1.000, effective CY 2011. For

For CY 2021, there are no proposed updates for GPCIs. CMS refers to updates for CY 2020 as the latest updates for GPCIs.

Evaluation and Management (E/M) Guidelines

Evaluation and Management (E/M) visits comprise nearly 40 percent of allowed charges for Physician Fee Schedule (PFS) services, and office/outpatient E/M visits make up nearly 20 percent of the allowed PFS charges. Nearly all specialties utilize and bill for E/M visits, for some this comprises the bulk of their charges. For other specialties that are more procedural based, the bulk of services billed are not E/M. Due to the volume of E/M visits billed each year and the fact the guidelines had not been updated since 1995 and 1997, CMS and the AMA have been working to revamp the outpatient new and established patient visits.

After publication of the CY 2019 MPFS final rules, it was clear CMS was making sweeping changes to Evaluation and Management (E/M) guidelines. Most of the changes were slated for CY 2021 as a means to give stakeholders time to prepare and the AMA time to jump on board and align their guidelines with CMS.

In the CY 2020 MPFS proposed ruling, CMS outlined cancelation of most if not all of the proposed changes and adjusting to the initial updates for E/M released by the AMA for CY 2021. CMS indicated they received many thousands of comments to the CY 2020 proposed ruling specific to E/M changes. Two of the codes CMS indicated would be available new in CY 2021 were HCPCS GPC1X, which is a special complexity add-on code and CPT® 99xxx, a prolonged service added to level 5 outpatient visits.

- *GPC1X - Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious, or complex chronic condition. (Add-on code, list separately in addition to office/ outpatient evaluation and management visit, new or established)*

- *99xxx - Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each 15 minutes (List separately in addition to codes 99205, 99215 for office or other outpatient Evaluation and Management services)*

CMS indicated code GPC1X recognizes the resources involved when practitioners furnish services best-suited to the patient's ongoing care, needs, and evolving illness. The specialty code is not limited to only certain specialties, but it would not be expected as a routine code billed in addition to an outpatient E/M visit. Instead

it reflects the time, intensity, and practice expense that practitioners will utilize when furnishing services to build long standing relationships, and not just those with chronic conditions or single high-risk issue, over longer periods of time.

Per CMS, "*…add-on code GPC1X could recognize the resources inherent in engaging the patient in a continuous and active collaborative plan of care related to an identified health condition the management of which requires the direction of a clinician with specialized clinical knowledge, skill and experience. Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals*."

Code 99xxx, for prolonged services, is billed in addition to level 5 new or established patient visit codes, 99205 and 99215. CMS clarified the expectation and application of this code from a time threshold standpoint. For example, code 99215, level 5 established outpatient visit, the time range is 40-54 minutes. According to CMS, if the billing practitioner spent 55 minutes with the patient, they could not bill the prolonged services code in addition to the level 5 visit code. They indicated if they allowed this, the practitioner would be double dipping their time as the prolonged services code represents 15-minute increments. In the scenario presented, the practitioner would be double counting 14 minutes, the last 14 minutes to meet the top threshold for 99215 and the first 14 minutes of the prolonged service to meet the additional 15 minutes.

CMS is proposing that 99xxx for prolonged services, when the practitioner uses the time-based method, the code could be selected when the outpatient office visit level 5 is exceeded by at least 15 minutes on the date of service of the actual visit. The following tables reflect the application of this add-on code with the proposed changes by CMS.

TABLE 22: Proposed Prolonged Office/Outpatient E/M Visit Reporting - New Patient

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and 99XXX x 1	89-103 minutes
99205 x 1 and 99XXX x 2	104-118 minutes
99205 x 1 and 99XXX x 3 or more for each additional 15 minutes.	119 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

TABLE 23: Proposed Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and 99XXX x 1	69-83 minutes
99215 x 1 and 99XXX x 2	84- 98 minutes
99215 x 1 and 99XXX x 3 or more for each additional 15 minutes.	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

Telehealth Services After the End of the Public Health Emergency

In response to COVID-19 and as part of the Public Health Emergency (PHE), CMS expanded telehealth services to be more broadly accepted and applicable than the system was prior to the pandemic. As part of the waivers and expansion, CMS has allowed for telehealth services to be provided in various settings, including office settings and the patient's home. As part of the Interim Final Rule released in both March and April 2020, CMS indicated when the PHE ends the waivers and expansions would also end, and services would revert back to pre-PHE days. As of the release of the CY 2021 MPFS Proposed Rule, there is no definitive end date to the PHE in sight. Health and Human Services (HHS) Secretary Alex Azar extended the PHE for another 90 days effective July 25, 2020. This would, at the very least, extend waivers and expansions through October 23, 2020.

CMS is proposing a phased-in end to the waivers and expansions for some items rather than a hard-and-fast stop. Specifically, CMS is proposing several changes to telehealth services moving forward which include the following:

- Create a Category 3 level of telehealth – this would allow for the services which meet the Category 1 and 2 telehealth services criteria to be added temporarily on an interim final basis as necessary and in response to this or another PHE.
- Any service added to Category 3 would remain on the Medicare telehealth services list through the calendar year in which the PHE ends. Services to be designated Category 3 through the year when the PHE ends can be found in Table 10 of the proposed rule.
- Most of the services added during the PHE to be removed as CMS, in review of the codes, did not find they met the Category 2 criteria already established for telehealth services. CMS is seeking comments from stakeholders if these services should be added to the Category 3 designation.
- Amend language to include when a code is deleted and replaced with a new CPT®/HCPCS code that describes the same clinical services of a code currently on the Medicare telehealth services list, the new code would be considered a successor to the old code and updated accordingly.

TABLE 12: Summary of CY 2021 Proposals for Addition of Services to the Medicare Telehealth Services List

Type of Service	Specific Services and CPT Codes
1. Services we are proposing for permanent addition to the Medicare telehealth services list	• Group Psychotherapy (CPT code 90853) • 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 E/Ms (HCPCS code GPC1X) • Prolonged Services (CPT code 99XXX) • Psychological and Neuropsychological Testing (CPT code 96121)
2. Services we are proposing as Category 3, temporary additions to the Medicare telehealth services list.	• 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 1-3 (CPT codes 99281-99283) • Nursing facilities discharge day management (CPT codes 99315-99316) • Psychological and Neuropsychological Testing (CPT codes 96130- 96133)
3. Services we are not proposing to add to the Medicare telehealth services list but are seeking comment on whether	• Initial nursing facility visits, all levels (Low, Moderate, and High Complexity) (CPT 99304-99306) • Psychological and Neuropsychological Testing (CPT codes 96136-96139)

they should be added on either a Category 3 basis or permanently.	• Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161-97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507) • Initial hospital care and hospital discharge day management (CPT 99221-99223; CPT 99238-99239) • Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT 99468-99472; CPT 99475-99476) • Initial and Continuing Neonatal Intensive Care Services (CPT 99477- 99480) • Critical Care Services (CPT 99291-99292) • End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962) • Radiation Treatment Management Services (CPT 77427) • Emergency Department Visits, Levels 4-5 (CPT 99284-99285) • Domiciliary, Rest Home, or Custodial Care services, New (CPT 99324-99328) • Home Visits, New Patient, all levels (CPT 99341- 99345) Initial and Subsequent Observation and Observation Discharge Day Management (CPT 99217- 99220; CPT 99224- 99226; CPT 99234-99236)

Telehealth Services Technology Requirements

During the PHE, CMS removed language and allowed for telehealth expanded services to be provided by *"multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner".* This allowed for the use of smartphones to be utilized by practitioners and patients when communicating with audio and video capability. CMS is proposing to update the last sentence of the Medicare telehealth services regulation which states: "*prohibits the use of telephones, facsimile machines, and electronic mail systems for purposes of furnishing Medicare telehealth services."* The regulation which prohibits the use of telephones could be confusing when a smartphone and the capabilities for the audio and video are used for the visit. By removing this verbiage, outdated references to technology would no longer be present and potentially create confusion.

Communication Technology-Based Services (CTBS)

As part of the CY 2019 MPFS Final Rule, CMS created several G-codes for services furnished via telecommunications technology. These services are not considered telehealth services but use telecommunications technology between the practitioner and patient. Two of the codes created include:

- G2010 - *Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment*
- G2012 - *Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*

Both of these codes may be billed by nonphysician practitioners (NPPs). CMS is also proposing two new codes to be added effective January 1, 2021. These new codes would also be billable by NPPs, consistent with their

scope of practice, for those who cannot bill independently for E/M services. The value of these codes would match G2010 and G2012 respectively.

- G20X0 – *Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment*
- G20X2 – *Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient, not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*

Audio-only Visits

Prior to the PHE CMS did not provide coverage for telephone services codes, 99441-99443. In large part, this is due to the fact the codes can be provided to the patient, parent, or guardian. CMS does not typically cover services or codes that are not directly provided to the patient themselves. However, as part of the PHE and feedback by stakeholders that most beneficiaries did not want to, know how to, or have the capabilities to use video technology for visits, CMS approved their coverage.

Telecommunication codes available prior to the PHE were only the short duration G-codes referenced above and CMS noted, for some patients, a longer telephone visit is needed. CMS is **not** proposing to recognize the telephone codes under MPFS after the PHE has ended. This is due to the requirement for telehealth services, moving forward after the PHE, audio/video capabilities are required. However, CMS is seeking comments on whether a service similar to the check-in visit should be created that covers a longer period of time for the visit. CMS is also seeking comments whether the audio-only visits should remain under provisional coverage until the end of year the PHE ends or if they should be part of the permanent MPFS payment policy.

Physician Supervision for Telehealth Services

CMS, for the duration of the PHE, has redefined direct supervision under MPFS to be provided through interactive real-time audio-video telecommunication technology. This allows the physician to provide real-time assistance and direction throughout a procedure or service by allowing them to see and interact with the staff member and patient without adding any unnecessary exposure. It is important to note, the supervision adjustments are meant as a minimum requirement. There may be circumstances in which the physical presence of the physician with the patient in the same location is necessary and more appropriate, for example administration of certain drugs or therapies. CMS stressed in these types of scenarios the physician and facility must make the best decision given the situation, even if this means potential exposure due to the nature of the scenario.

CMS is proposing to extend direct supervision expansion under MPFS to end later in the calendar year in which the PHE ends or December 31, 2021. This will allow, along with other waivers and extensions, an easement to the change in supervision than immediate pending the end of the PHE and for physicians and practices to prepare for the change back to the in-person requirement. CMS did note, if the PHE ends before the CY 2021 MPFS Final Rule is released, it is set to end October 23, 2020, the ability to use real-time audio and video technology to provide direct supervision would end during the period the PHE ends and the final rule is published.

CMS did clarify, the use of real-time audio and video technology to provide direct supervision under MPFS does not mean the physician must be actively observing and using the technology throughout the entire procedure. Instead the supervising physician is immediately available to engage via the real-time audio and video technology (excluding audio-only) throughout the procedure.

CMS has also received requests for clarification for when a physician and patient are at the same physical location, but the visit is provided using telecommunications technology if this can be billed as a telehealth visit. CMS did provide clarification for this in the Second Interim Final Rule released April 30, 2020. CMS states, "…*if audio/video technology is used in furnishing a service when the beneficiary and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person, and the service would not be subject to any of the telehealth requirements."*

Physician Supervision of Physician Assistant (PA) Services

Requests were made to CMS to allow for PAs to practice medicine without the required supervision by the physician, to align their roles and the regulations similar to those of nurse practitioners (NPs) and clinical nurse specialists (CNSs). As mentioned previously, the scope of work provided by PAs has changed over the years and many provide and deliver health care more broadly than ever before. Many of these changes have resulted in changes to the scope of work and laws in different states. Some states have relaxed their requirements related to the necessary supervision while others have yet to make any changes.

Currently, physicians and nonphysician practitioners (NPPs) can order diagnostic testing when the results are used by them to manage the patient related to a specific problem. Supervision of diagnostic services has been limited to physicians only as the services are paid under the Medicare Physician Fee Schedule (MPFS) and the minimum levels of supervision are assigned to the code. Supervision does not apply to NPs or CNSs as authorized under state law, but CMS is of the understanding in these scenarios the NP or CNS is working in collaboration with the physician.

Outside of the public health emergency (PHE) response to COVID-19, CMS requires general supervision of the PA by the physician. Due to the need to free up physicians and offer flexibility, CMS finalized, on an interim basis (for the duration of the PHE), the ability for NPs, CNSs, PAs, or Certified Nurse-Midwife (CNMs) to provide physician services as if the physician provided them. In addition, this flexibility will allow for payment under Medicare Part B as provided directly and "incident to" their own professional services, within the allowance of their state scope of practice. This specifically will allow NPs, CNSs, PAs, or CNMs to order, furnish directly, and supervise the performance of diagnostic tests as allowed under their state law for the duration of the PHE.

CMS is proposing to make the modifications permanent. This would allow for NPs, CNSs, PAs or CNMs to supervise diagnostic tests on a permanent basis as allowed by state law and scope of practice. CMS is also proposing that diagnostic tests performed by a PA in accordance with their scope of practice and state law do not require the specified level of supervision assigned to individual tests, because the relationship of PAs with physicians would continue to apply. In addition, CMS is proposing to make permanent the removal of the parenthetical, which was part of the COVID-19 Interim Final Rule, that required general supervision by the physician for diagnostic tests performed by the PA.

Waiver of the 60-day Delayed Effective Date for the Final Rule

CMS typically provides a 60-day delay in the effective date of the final rules after they are issued in accordance with the Congressional Review Act (CRA). In the event there is good cause that notice is unreasonable, unnecessary, or contrary to the public interest, the rule shall take effect as CMS deems appropriate.

Because CMS has allocated significant resources focused to combat COVID-19 PHE, work needed on the PFS final rule will not be completed within the usual schedule of at least 60 days before implementation of these rules. Therefore, CMS is waiving the 60-day delay in the effective date of the PFS final rule and replacing it with a 30-day in the effective date of the final rule after the publication date in the Federal Register. In addition, there will not be a 30-day delay in the effective day of the final rule because is not released with 60 days to prepare for implementation. The expected release date for CY 2021 MPFS Final Rule will be December 1, 2020 rather than November 1, 2020.

Submitting Comments

Comments to CMS regarding the MPFS proposed rule must refer to file code **CMS-1734-P** and must be received **no later than October 5, 2020**. Electronic and mail submissions are acceptable, electronic submissions are encouraged: http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.