Summary of the 2021 Medicare Physician Fee Schedule Final Rule

Updated January 5, 2021

On December 1, 2020, the Centers for Medicare and Medicaid Services (CMS) released the 2021 Medicare Physician Fee Schedule and Quality Payment Program final rule. The rule was accompanied by a fact sheet and press release. The AAFP provided comprehensive comments on the 2021 proposed rule in a September 28, 2020 letter.

2021 Medicare Physician Payment for Family Physicians

After CMS finalized the 2021 Fee Schedule, Congress passed legislation to increase the 2021 conversion factor. The new CY 2021 conversion factor is $34.8931, which is about 3 percent lower than the CY 2020 conversion factor but higher than the conversion factor that CMS planned to implement ($32.4085). This will positively impact family physicians in 2021.

While CMS previously estimated that the total Medicare allowed charges for family medicine would increase by 13 percent in 2021, the legislation passed at the end of 2020 will likely impact these estimations. CMS has not released updated impact estimates at this time.

Office/Outpatient Evaluation and Management Improvements

With the AAFP's support, CMS previously finalized changes to simplify billing and coding requirements for office-based Evaluation and Management (E/M) services. CMS also finalized higher relative values for these E/M services effective January 1, 2021. The agency reiterated in the 2021 final rule that these changes will go into effect as expected.

Congress delayed implementation of an add-on code that CMS previously finalized to account for the inherent complexity of primary care and other office visits. The AAFP strongly supported the implementation of this code, which was finalized as G2211, but physicians will not be able to bill this add-on code in 2021-2023.

Despite opposition from AAFP, CMS finalized a proposal to allow the prolonged services code to be billed only after the maximum total time of a level 5 E/M visit has been exceeded by at least fifteen minutes. Since the Medicare code definition will differ from the CPT prolonged services code, CMS created a new HCPCS code G2212 for prolonged patient visits to be used in place of the prolonged services code created by the CPT Editorial Panel.

With support from the AAFP, CMS finalized proposals to increase the values of certain codes commensurate with the increases to outpatient E/M services:

- Maternity services
- Transitional Care Management (TCM) Services
- Initial Preventive Physical Examination (i.e. "Welcome to Medicare" visit) and Initial and Subsequent Annual Wellness Visits
- Emergency Department Visits
- Some behavioral health services

Medicare Part B Payment for Immunization Administration

CMS reversed a proposal to increase payment rates for immunization administration, which the AAFP strongly supported, and is instead maintaining the 2019 and 2020 payment rates.

Personal Protective Equipment Payment Updates

Despite encouragement from the AAFP and broader medical community, CMS declined to implement a new CPT code to account for the increased cost of personal protective equipment amid the COVID-19 pandemic. The agency finalized this through an interim final rule, on which the AAFP will be commenting.

Medicare Telehealth Services

With the AAFP's support, CMS finalized a proposal to add the following codes permanently to the Medicare Telehealth Services List:

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

The agency also added several services to the Medicare Telehealth Services List on a temporary basis through December 31, 2021. The AAFP has encouraged CMS to expand access to telehealth services for all Medicare beneficiaries. If the public health emergency (PHE) extends into 2022, the following non-inclusive list of services would be included on the Medicare telehealth services list through December 31, 2022:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337)
- Home Visits, Established Patient (CPT 99349-99350)
- Emergency Department Visits, Levels 1-5 (CPT 99281-99285)
- Nursing facilities discharge day management (CPT 99315-99316)
- Hospital discharge day management (CPT99238- 99239)
- Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224-99226)

CMS indicates that when the PHE ends, the agency will again require remote patient monitoring services be furnished only to established patients.

CMS also did not extend the interim policy to permit billing for remote patient monitoring CPT codes 99453 and 99454 for fewer than 16 days in a 30-day period beyond the end of the PHE for COVID-19.

The agency did finalize a proposal to permanently allow consent to be obtained at the time CPT codes 99453 and 99454 are furnished. CMS also finalized the proposal to allow auxiliary personnel to furnish these services under general supervision of the billing physician or practitioner.

The proposal to allow CPT code 99439 for non-complex chronic care management services to be billed concurrently with TCM was also finalized with the AAFP's support.

Audio-only Telehealth Visits

CMS created a new virtual check-in code on an interim basis for the year of 2021 that can be used to bill for somewhat longer audio-only services. HCPCS code G2252 can be billed for a virtual check-in that includes 11-20 minutes of medical discussion if the service does not originate from a related E/M service in the previous 7 days or leads to a related E/M service or procedure within 24 hours or soonest available appointment. The AAFP advocated for the continuation of payment for audio-only E/M services after the end of the PHE. We will be commenting on this interim final rule.

Resident Moonlighting, Physician Supervision, and Scope of Practice

CMS permanently finalized their interim policy to allow residents to bill for services under the Medicare Physician Fee Schedule when the services provided are unrelated to their residency program. Residents will have to document that the services are separate and that they are fully licensed to practice medicine by the state in which services are provided. The AAFP supported this policy being made permanent.

With support from the AAFP, CMS finalized its interim policy to allow direct supervision via audio-video real-time technology until the end of the PHE or December 31, 2021, whichever comes later.

The agency also permanently finalized the following flexibilities for the supervision of residents furnishing services in rural areas (defined as outside a metropolitan statistical area):

- Teaching physicians can meet the requirements to bill for their services involving residents through a virtual presence using audio-video real-time communications technology. The teaching physician must be directly observing the furnished services.
- Teaching physicians can supervise the provision of Medicare telehealth services using real-time audio-video telecommunications technology.

CMS finalized several proposals related to the primary care exception for the duration of the PHE. First, teaching physicians can direct and review the services furnished by a resident during or immediately after the visit remotely using audio-video real time technology. Through the end of the PHE, Medicare can also pay the teaching physician for additional services under the primary care exception, including all levels of office E/M codes, audio-only telephone E/M services, transitional care management, and communications technology-based services.

CMS also permanently expanded the services permitted to be furnished under the primary care exception when they are furnished in residency training sites located outside of MSAs.

CMS finalized a proposal to allow nonphysician practitioners to supervise diagnostic tests if their state scope of practice laws permit them to do so. The AAFP opposed this proposal.

Quality Payment Program

CMS finalized the following policies for the Merit-based Incentive Payment System (MIPS):

- Despite strong support from the AAFP, CMS reversed their proposal to reduce the performance threshold to 50 due to the PHE and is instead increasing the performance threshold to 60 points.
- The exceptional performance threshold will remain at 85.
- The quality performance category weight is reduced to 40 percent while the cost performance category will be weighted at 20 percent. The AAFP opposed this. The promoting interoperability and improvement activities performance categories will continue to be weighted at 25 and 15 percent, respectively.
- CMS will move forward with a continuous 90-day performance period for the promoting interoperability category.
- The implementation of MIPS Value Pathways (MVPs) is delayed until performance year 2022.
- CMS is updating cost measures to include telehealth services.
- The Web Interface will be retired as a reporting mechanism in 2022.

For the 2021 performance year, CMS is allowing eligible clinicians to apply for an extreme and uncontrollable circumstances exception. Groups, virtual groups, and alternative payment model (APM) entities can also apply for an exception. Given the COVID-19 pandemic, CMS is finalizing the proposal to increase the complex patient bonus to 10 points. Although the AAFP strongly urged CMS to automatically apply the extreme and uncontrollable circumstances exception to all MIPS-eligible clinicians for the 2020 performance period, the agency confirmed they will not automatically apply it.

CMS finalized the proposal to end the APM Scoring Standard and implement the APM Performance Pathway (APP). The APP is comprised of a fixed set of measures for each performance category. The AAFP supported implementation of the APP and strongly encouraged CMS not to eliminate the APM Scoring Standard.

The agency is also moving forward with the proposal to modify the Qualifying APM Participant (QP) threshold score calculation. CMS also finalized a proposal to allow targeted reviews for QPs and partial QPs that believe they were erroneously excluded from an APM Entity's Participation List.

CMS finalized a policy, which was not in the proposed rule, to evaluate clinicians in a MIPS APM for eligibility at the individual and group levels. They will no longer evaluate APM Entities for the low-volume threshold.

Medicare Shared Savings Program (MSSP)

MSSP accountable care organizations (ACOs) will be required to report quality data via the APP in 2021.

In 2021, ACOs will meet the quality performance standard for shared savings if the score is equal to or higher than the 30th percentile. In performance year 2023, this level will increase to the 40th percentile.

CMS is delaying the update to its extreme and uncontrollable circumstances policy until 2023. Under the new policy, an ACO affected by extreme and uncontrollable circumstances would receive the minimum quality performance score equal to the 40th percentile. If an ACO submits quality data, CMS would use the higher of the ACO's MIPS quality performance score or the 40th percentile MIPS quality performance category score. CMS is proposing to expand the list of primary care services used in beneficiary assignment.

Federally Qualified Health Centers (FQHCs)

CMS is finalizing the proposal to rebase and revise the FQHC market basket to reflect a 2017 base year. This will update the data that is used for payment to reflect more recent cost data.