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SPECIAL ISSUE

Coverage of the final 2021 Medicare physician fee schedule and Quality Payment Program

In this issue

1, 11 **Physician payments**
10% conversion factor cut offsets E/M gains, with wild fluctuations on the horizon
Fees and payment indicators complete the picture for new codes

3, 6 **2021 E/M office visits**
Simplify the visit complexity code: Forget specialty, focus on continuity
With HCPCS debut, take note of new rules for prolonged services

5 **Benchmark of the week**
2021 Part B fee projections: Top specialties adding — and losing — revenue

6 **Telehealth**
Telehealth expands even more, but will mostly go away unless Congress acts

9 **Quality Payment Program**
APP debut, benchmark stasis, small changes mark QPP in PFS

10 **Alternative payment models**
Shared Savings gets routed into APP, but keeps Web Interface for one more year

12 **MDPP**
CMS finalizes MDPP changes; program all-virtual until the PHE ends

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Physician payments

10% conversion factor cut offsets E/M gains, with wild fluctuations on the horizon

You'll find a steep cut to the Medicare Part B conversion factor (CF) in 2021, in one part of a systemwide redistribution of the more than $100 billion in annual Part B provider payments. The CF falls 10.2% to a rate of $32.41 in 2021, down from $36.10 in 2020.

The double-digit decrease to the CF, which is slightly better than the 11% cut floated in the proposed rule in August that, at the time, led to outcry among many provider organizations, comes in response to large pay gains awarded to an oft-reported basket of E/M services – the series of office visit codes **99202-99215**.

Calculation of the CY 2021 PFS conversion factor

CY 2021 conversion factor (before adjustments)	$36.0896
Statutory update factor	0%
CY 2021 RVU budget neutrality adjustment	-10.20%
Final CY 2021 conversion factor	$32.4085

Source: Final 2021 Medicare physician fee schedule, released Dec. 1

As confirmed in the final 2021 Medicare physician fee schedule that CMS released Dec. 1, the agency has accepted the revised relative value units (RVU) for the basket of E/M office visit codes that the AMA approved under a recent revaluation process. **Example:** The total non-facility RVUs for code 99214, the most frequently reported office service, go from 3.06 in 2020 to 3.81 in 2021, a 25% gain. The RVU increases for 99212 (31%), 99213 (27%) and 99215 (30%) are also significant.

2021 physician fee schedule: Plan now

CMS has an array of topics under its scope as the calendar flips to the new year, including an overhaul of the E/M office visit (99202–99215) documentation guidelines and fees. Prepare a path for success in 2021 with a comprehensive overview of the physician fee schedule during the Dec. 16 live webinar **2021 Medicare Physician Fee Schedule: Prepare for E/M Shift, Fee Updates, and More.** Learn more: https://codingbooks.com/YMPDA121620.

Yet the slashed CF is dampening the effects of the revalued RVUs, and it is expected to result in fee cuts for dozens of specialties. Consider the outlook of 99214 allowable charges in 2021: While the RVUs went up 25%, the actual fee per service rises just 10.6%.

Yet to better align the RVU expectations and allowable charges, CMS also finalized a primary care add-on code, **G2211**, which is projected to pay roughly $16 per claim (*see story, p. 3*). The agency assumes the vast majority — around 90%, CMS says — of E/M encounters will be eligible for the G2211 add-on code. Padding the E/M office visit fees with an extra $16 per encounter pushes the allowable charges into the territory of the RVU valuations.

"I have to say, this is what they said they wanted to do, and they're doing it," says Betsy Nicoletti, president of Medical Practice Consulting in Northampton, Mass., about CMS' focused attention on increasing fees for primary care services. "They're putting their money where their mouth is. I think it's important for the health of our country that we pay more for this type of care."

Some rise, others fall

The money that's getting redirected to primary care services will have broad repercussions on the remainder of the Part B pool of allowable charges. Nearly two dozen specialties are expected to see a net pay cut of at least 5% in 2021, with radiology, nurse anesthesia/anesthesia assistant and chiropractor on pace for a 10% reduction in allowable charges (*see benchmark, p. 5*).

Others, including endocrinology (+16%) and family practice (+13%), are scheduled for big pay gains. Perhaps not surprisingly, the public comments that CMS fielded in the weeks leading up to the release of the final rule were largely flavored by the 2021 fee projections.

"In general, commenters from physician specialties who saw projected increases related to our previously finalized revaluation of the office/outpatient E/M code set, our implementation of HCPCS code G2211, and our revaluations of services analogous to office/outpatient E/Ms were supportive," CMS relays in the final rule, "while those commenters from physician specialties who projected decreases objected."

Numerous groups and associations urged CMS to take action under the COVID-19 public health emergency (PHE) and waive the budget neutrality requirement that mandates similar year-to-year fee projections. But CMS balked, indicating that Congress would have to intervene to allow for a spending increase.

"The statutory waiver authorities available to the Secretary following a public health emergency declaration … do not include waiver authority that would allow for implementation of changes to the PFS outside of the budget neutrality requirements in statute," the agency says in the final rule.

Calculation of the CY 2021 anesthesia conversion factor

CY 2021 conversion factor (before adjustments)	$22.2016
Statutory update factor	0%
CY 2021 RVU budget neutrality adjustment	-10.20%
CY 2021 practice expense and malpractice adjustment	0.59%
Final CY 2021 anesthesia conversion factor	$20.0547

Source: Final 2021 Medicare physician fee schedule, released Dec. 1

Fee and RVU projections for E/M services, 2020 vs. 2021

Code	2020 Total RVUs	2020 CF	2020 Fee	2021 Total RVUs	2021 CF	2021 Fee	YTY Fee Change	YTY % Change
99202	2.14	$36.09	$77.23	2.13	$32.41	$69.03	-$8.20	-11.9%
99203	3.03	$36.09	$109.35	3.28	$32.41	$106.30	-$3.05	-2.9%
99204	4.63	$36.09	$167.09	4.93	$32.41	$159.77	-$7.32	-4.6%
99205	5.85	$36.09	$211.12	6.51	$32.41	$210.98	-$0.14	-0.1%
99211	0.65	$36.09	$23.46	0.68	$32.41	$22.04	-$1.42	-6.4%
99212	1.28	$36.09	$46.19	1.67	$32.41	$54.12	$7.93	14.6%
99213	2.11	$36.09	$76.15	2.68	$32.41	$86.85	$10.71	12.3%
99214	3.06	$36.09	$110.43	3.81	$32.41	$123.48	$13.04	10.6%
99215	4.11	$36.09	$148.33	5.33	$32.41	$172.74	$24.41	14.1%

Source: Part B News *analysis of the final 2021 Medicare physician fee schedule, including supplementary materials*

Finalized: 2021 E/M documentation changes

The old regime of E/M documentation guidelines is fading away, as a new paradigm comes into play for E/M office visit codes (**99202-99215**) on Jan. 1. The changes, developed in collaboration with the AMA, will eschew the 1995 and 1997 documentation guidelines and the rigorous history, exam and medical decision-making elements that defined code level selection.

"Under this new CPT coding framework, history and exam will no longer be used to select the level of code for [office/outpatient] E/M visits," CMS states. "Instead, an [office/outpatient] E/M visit will include a medically appropriate history and exam, when performed. The clinically outdated system for number of body systems/areas reviewed and examined under history and exam will no longer apply, and the history and exam components will only be performed when, and to the extent, reasonable and necessary and clinically appropriate."

All of the updates to the E/M documentation guidelines that CMS and the AMA have touted for more than a year are coming into play, with almost no surprises, Nicoletti says. The only curveball is the new prolonged services code (**G2212**) that CMS debuted in the final rule (*see story, p. 6*). — *Richard Scott (rscott@decisionhealth.com)* ■

RESOURCE

- Final 2021 Medicare physician fee schedule: *https://public-inspection.federalregister.gov/2020-26815.pdf*

2021 E/M office visits

Simplify the visit complexity code: Forget specialty, focus on continuity

You can earn an additional $16 for E/M office visits next year when the treating physician or other qualified health care professional acts as a "focal point of care."

CMS announced the debut of a HCPCS add-on code, **G2211,** that applies to E/M services that help providers "to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time," CMS explains in the final 2021 Medicare physician fee schedule.

Previously, CMS had held the add-on service with placeholder code **GPC1X**. Here you will find the finalized descriptor for the new add-on code (*emphasis added)*:

- G2211 (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 condition or a complex condition*. [Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established]).

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Any primary care provider or specialist may use the code for any level office visit (**99202-99215**) when the treating practitioner provides the care described by the code.

"The add-on code is not intended to reflect a difference in payment by specialty, but rather recognition of a different per visit resource cost based on the kinds of care practitioners provide, regardless of Medicare enrollment specialty," says Maxine Lewis, CMM, CPC, CPC-I, CPMA, CCS-P, president, Medical Coding Reimbursement Management, Cincinnati.

Discover G2211 scenarios

CMS suggests several ways to determine if it is appropriate to report G2211, including "diagnoses, the practitioner's assessment and plan for the visit, and/or other service codes billed could serve as supporting documentation." Two additional indicators are:

1. The physician or qualified health care professional (QHP) provides one or more care management services to the patient. You'll find a complete list in Table 17 of the final rule, but services include advance care planning, prolonged services with an office visit, treatment and management based on remote physiologic monitoring data and any of the non-face-to-face care management services such as chronic care management.
2. The physician or QHP routinely provides preventive services for the patient.

Use the following scenarios and guidance to determine when you would — and would not — add G2211 to a visit:

Scenario 1: CMS gives the example 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 three 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."

Scenario 2: Another example would be a patient with type 2 diabetes and hypertension who "has scheduled appointments at appropriate intervals, so her doctor manages her overall health," says Shannon McCall, RHIA, CCS, CCS-P, CPC, CPC-I, CEMC, CRC, CCDS, CCDS-O, director of HIM/coding for HCPro, a subsidiary of Simplify Compliance. The doctor treats the patient's chronic conditions and any acute ones she develops, like the flu. When the patient is diagnosed with atrial fibrillation during a regular appointment the doctor refers the patient to a cardiologist for evaluation, "so he serves as a care coordinator when needed," McCall explains.

In both examples, the physicians serve as what CMS describes as the "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."

"Specialists like oncology or rheumatologists also could report this code since they treat a single, serious or complex condition for a patient on an ongoing basis and is not just for the short term," McCall says.

A specialist who "serves as a focal point of care for a patient's overall health needs over a period of time," may also report the code, CMS says.

Practices should also understand when it is not appropriate to report G2211, such as when the patient has a serious or complex condition, but the practitioner does not address it.

"It would not be appropriate for a provider who sees a patient from time to time to treat acute conditions to report this code on every visit," McCall says. For example, if a family practice doctor only sees the patient when the patient is sick or injured and is not providing "consistent, ongoing care," it wouldn't apply, McCall adds.

CMS describes this type of practitioner/patient relationship as "discrete, routine or time-limited," and lists services such as referral for removal of a mole, treatment of a fracture, and counseling for seasonal allergies as examples of treatments that aren't enough to justify G2211.

(*continued on p. 6*)

Benchmark of the week

2021 Part B fee projections: Top specialties adding – and losing – revenue

It's a topsy-turvy fee outlook in 2021, as medical practices are projected to see wild fluctuations in Part B charges in the new year. With specialty-specific gains reaching as high as 16% – and losses also reaching double digits – your billing patterns are likely to tell how your Medicare charges will fare.

The following chart, featuring data published in the final 2021 Medicare physician fee schedule released Dec. 1, reveals the specialty-level impact of a massive fee redistribution that takes effect Jan. 1. As the chart shows, endocrinology tops expected fee gains in 2021, with a 16% net accrual. Multiple specialties, including radiology and nurse anesthetist, are in line for a 10% fee loss.

"The estimated impacts for some specialties, including endocrinology, rheumatology, family practice and hematology/oncology reflect increases relative to other physician specialties," CMS states in the final rule. "These increases can largely be attributed to previously finalized policies for increases in valuation for office/outpatient E/M visits which constitute nearly 20% of total spending under the PFS." – *Richard Scott* (rscott@decisionhealth.com)

Top 10 specialty winners, projected impact on total allowed charges, CY 2021

Specialty	Allowed charges (mil)	Impact of work RVU changes	Impact of PE RVU changes	Impact of MP RVU changes	Combined impact
Endocrinology	$508	10%	5%	1%	16%
Rheumatology	$548	10%	5%	1%	15%
Hematology/Oncology	$1,707	8%	5%	1%	14%
Family practice	$6,020	8%	4%	0%	13%
Allergy/Immunology	$247	5%	4%	0%	9%
Physician assistant	$2,901	5%	2%	0%	8%
General practice	$412	5%	2%	0%	7%
Nurse practitioner	$5,100	5%	3%	0%	7%
Obstetrics/Gynecology	$636	4%	3%	0%	7%
Psychiatry	$1,112	4%	3%	0%	7%

Top 10 specialty losers, projected impact on total allowed charges, CY 2021

Specialty	Allowed charges (mil)	Impact of work RVU changes	Impact of PE RVU changes	Impact of MP RVU changes	Combined impact
Anesthesiology	$2,020	-6%	-1%	0%	-8%
Cardiac surgery	$266	-5%	-2%	0%	-8%
Interventional radiology	$499	-3%	-5%	0%	-8%
Nuclear medicine	$56	-5%	-3%	0%	-8%
Thoracic surgery	$352	-5%	-2%	0%	-8%
Pathology	$1,265	-5%	-4%	0%	-9%
Physical/Occupational therapy	$4,973	-4%	-4%	0%	-9%
Chiropractor	$765	-7%	-3%	0%	-10%
Nurse anesthetist/Anesthesia assistant	$1,321	-9%	-1%	0%	-10%
Radiology	$5,275	-6%	-4%	0%	-10%

Source: Part B News *analysis of 2019 Medicare claims data, the latest available*

(*continued from p. 4*)

Watch for more from CMS

CMS has great expectations for G2211 — it expects high utilization and projects that claims will return roughly $2.5 billion in 2021 alone, according to CMS data. But it did promise to keep an eye on use and issue additional guidance. Practices may decide to hold off on reporting this code until they're comfortable with the new guidelines for office visits. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

2021 E/M office visits

With HCPCS debut, take note of new rules for prolonged services

You will count time in two ways if you report a prolonged service with an E/M office visit that is coded based on time next year. CMS calls CPT code **99417** — the add-on code for prolonged services — unclear and believes it can result in double-counting of time because the descriptor does not push far enough past the minimum time for the related office visit (**99205** or **99215**).

To resolve the dilemma, CMS created add-on code **G2212**, which it will require on Medicare claims in 2021. Here's the full descriptor:

- G2212 (Prolonged office or other outpatient evaluation and management service[s] beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact [List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services] [Do not report G2212 on the same date of service as **99354, 99355, 99358, 99359, 99415, 99416**]. [Do not report G2212 for any time unit less than 15 minutes]).”

The following chart contains required times for G2212. Check with your private payers to find out if they will accept the prolonged service and which code you should report.

Visit code/add-on code	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 and G2212 x 3 or more for each additional 15 minutes.	119 minutes or more
99215	40-54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes.	99 minutes or more
Source: *CMS 100-04, Change Request 12071*	

99358-99359 curtailed

CMS will not cover non-face-to-face prolonged service codes performed in conjunction with an office visit next year, which means office visits coded based on time will be limited to tasks performed on the day of the face-to-face visit.

However, CMS may revisit the idea. “We are not opposed in concept to reporting prolonged office/outpatient visit time on a date other than the visit, but we believe there should be a single prolonged code specific to O/O E/M visits that encompasses all related time,” CMS says in the final rule. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

Telehealth

Telehealth expands even more, but will mostly go away unless Congress acts

In the final rule, CMS cleared dozens of telehealth and telehealth-adjacent codes that nearly all providers can use right now. However, many of them are slated to be removed from general use after the COVID-19 public health emergency (PHE). A few codes, though, are exempt from the traditional telehealth rules.

CMS added nine Category 1 codes for telehealth. These are services that are similar to professional consultations, office visits and office psychiatry services that are currently on the Medicare telehealth services list: group psychotherapy (**90853**); psychological and neuropsychological testing (**96121**); domiciliary, rest home or custodial care services, established patients (**99334-99335**); home visits, established patients (**99347-99348**); cognitive assessment and care planning services (**99483**); visit complexity inherent to certain office/outpatient E/M (**G2211**); and prolonged services (**G2212**).

The agency also added dozens of "Category 3" codes — including home visits, emergency department visits and discharge management codes — that "will remain on the list through the calendar year in which the PHE ends."

The bad news is most of these codes will eventually go back to the old telehealth rules — reversing the wave of adoption prompted by the PHE — if Congress does not change the law. In the meantime, CMS reports that it will conduct "a commissioned study, analysis of Medicare claims data or another assessment mechanism, to further study the impacts of this limited permanent expansion of the virtual presence policy to inform potential future rulemaking, and in an effort to prevent possible fraud, waste and abuse."

Some codes stay

Some remote codes, however, may still be with you after the PHE.

CMS has been trying to thread the needle on telephone codes, including telephone E/Ms, that it enabled for the pandemic without downgrading care (*PBN 12/3/20*).

"We recognized that the need for audio-only interaction could remain as beneficiaries continue to try to avoid sources of potential infection, such as a doctor's office," the agency says in the final rule. "In that circumstance, a longer phone conversation may be needed to determine if an in-person visit is necessary rather than what is described by the virtual check-in."

CMS will stop paying separately for telephone E/M codes **99441-99443** after the PHE ends, but it has created an interim code, **G2252,** for a "brief communication technology-based service (e.g., virtual check-in)," to be used for established patients for the remainder of the PHE and, if it ends sooner, to the end of 2021. The code covers an 11-20 minute "medical discussion," similar to 99442, and is used "when the acuity of the patient's problem is not necessarily likely to warrant a visit, but when the needs of the particular patient require more assessment time from the practitioner," CMS states in the rule.

Because G2252 is a communications technology-based service (CTBS) similar to a virtual check-in, "it does not have the same location-dependent restrictions applied to telehealth services and can be used beyond the expiration of the public health emergency," says Gary Call, M.D., chief medical officer of health care consultancy HMS in Irving, Texas. "The availability of reimbursement for this code allows providers to check on a patient's condition or answer complex questions to determine if the patient needs to be seen for an in-person evaluation."

Patrick McEneaney, M.D., owner and CEO of Northern Illinois Foot & Ankle Specialists, a 15-doctor practice with nine locations, says that he's found virtual check-ins extremely useful.

Summary of CY 2021 services added to the Medicare telehealth list

Type of service	Specific services and CPT codes
Services we are finalizing for permanent addition as Medicare telehealth services	• Group psychotherapy (CPT 90853) • Domiciliary, rest home or custodial care services, established patients (CPT 99334-99335) • Home visits, established patient (CPT 99347-99348) • Cognitive assessment and care planning services (CPT 99483) • Visit complexity inherent to certain office/outpatient E/Ms (HCPCS G2211) • Prolonged services (HCPCS G2212) • Psychological and neuropsychological testing (CPT 96121)"
Services we are finalizing to remain temporarily on the Medicare telehealth list through the end of the year in which the PHE for COVID-19 ends (Category 3 services), to allow for continued development of evidence to demonstrate clinical benefit and facilitate post-PHE care transitions.	• 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) • Psychological and neuropsychological testing (CPT 96130-96133; CPT 96136-96139) • Therapy services, physical and occupational therapy, all levels (CPT 97161-97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507) • Hospital discharge day management (CPT 99238-99239) • Inpatient neonatal and pediatric critical care, subsequent (CPT 99469, 99472, 99476) • Continuing neonatal intensive care services (CPT 99478-99480) • Critical care services (CPT 99291-99292) • End-stage renal disease monthly capitation payment codes (CPT 90952, 90953, 90956, 90959, and 90962) • Subsequent observation and observation discharge day management (CPT 99217; CPT 99224-99226)"
Services we are not adding to the Medicare telehealth list either permanently or temporarily.	• Initial nursing facility visits, all levels (low, moderate and high complexity) (CPT 99304-99306) • Initial hospital care (CPT 99221-99223) • Radiation treatment management services (CPT 77427) • Domiciliary, rest home or custodial care services, new (CPT 99324-99328) • Home visits, new patient, all levels (CPT 99341-99345) • Inpatient neonatal and pediatric critical care, initial (CPT 99468, 99471, 99475, 99477) • Initial neonatal intensive care services (CPT 99477) • Initial observation and observation discharge day management (CPT 99218-99220; CPT 99234-99236) • Medical nutrition therapy (CPT G0271)"
Source: *Final 2021 Medicare phyisician fee schedule, Table 16*	

"I've had patients who maybe wouldn't have called for a real appointment because they didn't think it was that big a deal, but because they didn't want to leave their house they called us and we found some problem [needing attention] that maybe they would have waited on," McEneaney says.

Other CTBS service codes cleared in the final rule include **98970-98972** (Qualified nonphysician health care professional online digital evaluation and management service) and the "sometimes therapy" codes **G2250, G2251, G2061, G2062** and **G2063**.

Given the imminent departure of many telehealth codes, Call suggests that providers "use this time during the PHE to get patients established on good care plans, monitoring adherence to those care plans and helping patients to understand the benefits of following their care plan."

Addressing patients' social determinants of health, for example, is something providers can dig into now, with the help of telehealth services. "Providers should plan for when telehealth services will no longer be covered and help patients make sure they have appointments for in-person visits to continue their care when the PHE ends," Call says. — *Roy Edroso (redroso@decisionhealth.com)* ■

Quality Payment Program

APP debut, benchmark stasis, small changes mark QPP in PFS

Aside from the delay of the MIPS Value Pathways (MVP) and the advance of the APM Performance Pathway (APP), the adjustments to the Quality Payment Program (QPP) and the Merit-Based Incentive Payment System (MIPS) do not veer too far from previous versions of the program. Yet experts warn that even minor changes can have a big impact on your performance.

Nearly all the QPP and MIPS changes in the proposed rule have been finalized, including the mostly technical, QP-defining changes for the Advanced APM program in what looks like its least eventful season since QPP began in 2017 (*PBN 8/13/20*). And the upheaval promised by the MVP overhaul has been pushed back a year (*PBN 8/15/19*).

That doesn't mean you should ignore MVP for another year, though.

"We're telling clients to begin preparing for it," says David Halpert, chief, client team at Roji Intelligence, a registry and consultancy in Chicago. "Look at some of the areas where you perform well that you want to demonstrate."

CMS has made related documents, including MVP "candidate submissions" for measures, available for download (*see resources, below*).

APP makes its debut

About the most impactful change is the launch of APP as a reporting mandate for MIPS alternative payment models (APM). Heretofore, MIPS APM reporters were required, and other groups of 25 eligible clinicians (EC) or more had the option, to report MIPS via the CAHPS for MIPS survey and Web Interface.

The APP reporting method that's debuting in 2021 was designed to accompany the proposed MIPS Value Pathways (MVP) relaunch of MIPS, based on fewer and better integrated measures (*PBN 8/13/20*). It will be reportable in 2021 only by MIPS APM participants, i.e., individual EC, group or APM Entities, and Shared Savings accountable care organizations (ACO).

APP reduces the number of reported quality measures from 10 to six — and, with two of the APP measures being auto-reported administrative claims measures, that leaves CAHPS for MIPS and three quality measures to be reported for 2021. Note that while CAHPS was waived for most reporters in 2020, it is still required for 2021 unless waived for extreme and uncontrollable circumstances, and the three quality measures must be reported based on all patient data, including that of non-Medicare patients (*see related story on APP for Shared Savings ACOs, p. 10*).

MVP has been delayed a year, and APP can be, too, if MIPS APM reporters want, because CMS decided in the final rule to wait a year to end Web Interface. Web Interface takes a sampling of the reporting entity's patient data and scores the entity in 10 categories. But after this year, you'll have no choice.

Quality pitfalls

One surprise in the final rule is the decision to move the MIPS performance threshold — that is, the total points from all four categories that must be met to avoid a penalty — from 50 points to 60.

The weights for the four categories remain the same as in the proposed rule — 40% for quality, 20% for cost, 25% for promoting interoperability and 15% for improvement activities. The exceptional performance threshold, at which participants become eligible for more bonus money, remains at 85 points.

While the threshold in 2021 should be achievable by most reporters, meeting the threshold will get tougher in 2022, warns Lauren Patrick, president and CEO of Healthmonix in Malvern, Pa. That year, "the anticipated threshold for penalty avoidance [will be] somewhere between 74 and 80 [points]" Patrick predicts, and she thinks that "50% of the providers will be in the 'penalty box' for 2022.

"The incentives and penalties will increase and the program truly will be a competitive market," Patrick adds.

CMS is removing 11 quality reporting measures, and adding two administrative claims measures covering big-ticket medical expenses: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups, and Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS Eligible Clinicians.

"By adding administrative claims measures, CMS is sort of tipping its hand to say, we're looking at cost more than we used to, so brace yourself: value-based care is here to stay, and you are going to be seeing it in all facets of the program, not just the formal cost component," Halpert says.

CMS is also making changes to 94 other quality measures, which Patrick advises that you examine carefully.

"There are significant changes in denominations to include telehealth, changes in eligible visit codes, exclusions and exceptions, and some numerators," she says.

For example, CMS makes several revisions to D.4 Coronary Artery Disease (CAD): Beta-Blocker Therapy — Prior Myocardial Infarction (MI) or Left Ventricular Systolic Dysfunction (LVEF < 40%), including an update to the "eCQM Specifications collection type logic to improve alignment with measure intent as it will add constraints to help prevent double counting of patients," and the addition of telehealth to the denominator.

"Many measures are being refined to exclude patients with advanced illness and frailty," Patrick adds. "Quality measure reporting is becoming more precise as CMS again attempts to level the reporting field and reflect good quality care in the measures."

Also, while cost, reported automatically based on claims, is 20% of your MIPS score in 2021, it is slated to go to 30% in 2022 — as is quality.

Very light changes were made to the other categories; the "Partner in Patients Hospital Engagement Network" improvement activity is removed because the Partnership for Patients Hospital Engagement Network with which it was involved has shut down, and in promoting interoperability the big change is the addition of a Health Information Exchange (HIE) bi-directional exchange measure, which can be reported to cover the HIE objective requirement.

Benchmark reprieve

Another area where CMS backed off from the proposed rule is quality benchmarks. The agency had proposed to move to same-year performance-period benchmarks to score quality measures for the 2021 performance period because it thought the public health emergency (PHE) would hinder collection. Traditionally, it has used historical benchmarks from previous years as a measuring stick. The agency says it now feels it has sufficient data to stick with the historical formula.

Halpert believes providers dodged a bullet there, as performance-period collection meant they'd be figuring out your benchmark based on your peers' behavior "on the fly," and you wouldn't know until after you submitted by what standard your performance would be judged.

He compares it to the old PQRS reporting system "when you would turn in your homework at the end of the year and you wouldn't know much anything until summer or fall when the PQRS feedback reports came out. Having the historical benchmarks established during the year is really helpful because they can see right away if there is an issue with their performance compared to others. Then they can take steps to address it and actually improve — which is the whole point of the quality measures." — *Roy Edroso* (*redroso@decisionhealth.com*) ■

RESOURCE

- QPP final rule documents including MVP Development Standardized Template (zip file): https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1207/2021%20QPP%20Final%20Rule%20Resources.zip

Alternative payment models

Shared Savings gets routed into APP, but keeps Web Interface for one more year

The Quality Payment Program (QPP) portion of the final 2021 Medicare physician fee schedule undergoes one major change — a new quality reporting method with both upsides and downsides — but participating accountable care organizations (ACO) get to hang onto the Web Interface option for one more year.

The new reporting method, APM Performance Pathway (APP), is on for MIPS alternative payment model (APM) reporters in 2021 as well as for Shared Savings ACOs (see related story, p. 8). Shared Savings ACOs can use the Web Interface reporting model instead for 2021, but must use APP in 2022.

While Shared Savings ACOs had their CAHPS reporting waived for 2020, they will be required to report it in 2021 in either case.

The good news is that APP requires only three measures to be reported, according to David Halpert, chief, client team at Roji Intelligence, a registry and consultancy in Chicago. The three measures — Diabetes: Hemoglobin A1c (HbA1c) Poor Control (>9%); Preventive Care and Screening: Screening for Depression and Follow-Up Plan; and Controlling High Blood Pressure — are far fewer than the 10 measures demanded of the Web Interface method. The bad news is that APP offers less choice to the ACO, which could lead to lower scores.

"While there are fewer measures, the big difference between reporting for an ACO and what they do today is that now they're given a list of patients from Medicare, regardless of the size of their ACO," Halpert says.

With Web Interface, "whether you have 10,000 attributed patients or 100,000 attributed patients, they send out a list of measures by category with a list of 248 consecutively ranked beneficiaries from the Web Interface sample per category," Halpert explains. "And the categories are things like preventive screening, diabetes care, etc. So, you've got a cap on it. And it's a small enough pool that even if you don't have all the EHRs in your ACO linked up, a team of industrious providers or care coordinators or whoever can go through, do some chart review, and ensure that all 248 of those people have a response."

But with APP, "the measures [are] calculated based on the size of the population — and based on all your patients, not just your Medicare patients. So you've now applied these three measures to the entirety of the ACO population, not just Medicare [patients]," Halpert says. "Some of these ACOs are going from, let's say, 1,000 patients for which they would need to collect data to tens of thousands and hundreds of thousands of patients because it's all payers — and there's no way for them to be able to do that via chart review."

One new measure, Screening for Clinical Depression, "is going to be a real challenge for a lot of them," Halpert says, "because it's not something currently being documented in a consistent manner or even at all, often."

Also, while other measures like A1c for diabetes patients and blood pressure for patients with hypertension can be easily recorded in discrete fields in your electronic health record (EHR), many systems won't have anything like that for depression scores — and different parts of the ACO may not even have one scale they all use.

For reporters with this problem, the one-year Web Interface reprieve gives some breathing room, but "what they will need to do is, if the various EHRs within the ACO aren't linked up, they need to get moving on that very, very quickly."

CMS also made a number of technical changes to the methodology for determining beneficiaries and share of savings for Shared Savings ACOs. Also, while those ACOs currently have to achieve a quality score equivalent or greater than the 30th percentile of all MIPS quality score, by performance year 2023 that will go up to the 40th percentile. — *Roy Edroso* (redroso@decisionhealth.com) ■

Physician payments

Fees and payment indicators complete the picture for new codes

Take a look at the final payment determinations for codes that will go into effect Jan. 1, 2021. The list includes 39 codes that were previewed in the proposed 2021 Medicare physician fee schedule and four codes CMS created in the interim, including the replacement prolonged service code (**G2212**) and the extended virtual check-in code (**G2252**).

The fees are par., national, non-facility unless there is an (F) after the fee, which indicates a facility payment because CMS did not set a non-facility practice expense for the service. Status code C indicates the service is carrier-priced. Indicators I (invalid), N (non-covered) or X (statutory exclusion) indicate the codes are not reimbursed by Medicare. — *Julia Kyles, CPC (jkyles@decisionhealth.com)* ■

Code	Descriptor	2021 fee
30468	Rpr nsl vlv collapse w/implt	$2,889.22
32408	Core ndl bx lng/med perq	$916.51
33741	Tas congenital car anomal	$726.60 (F)
33745	Tis cgen car anomal 1st shnt	$1,021.84 (F)
33746	Tis cgen car anomal ea addl	$402.19 (F)
33995	Insj perq vad r hrt venous	$347.10 (F)
33997	Rmvl perq right heart vad	$154.26 (F)
55880	Abltj mal prst8 tiss hifu	$942.76 (F)
57465	Cam cervix uteri drg colp	$54.45
69705	Nps surg dilat eust tube uni	$3,085.29
69706	Nps surg dilat eust tube bi	$3,176.68
71271	Ct thorax lung cancer scr c-	$141.95

Code	Descriptor	2021 fee
76145	Med physic dos eval rad exps	$806.32
92229	Img rta detc/mntr ds poc aly	C
92517	Vemp test i&r cervical	$81.35
92518	Vemp test i&r ocular	$75.51
92519	Vemp tst i&r cervical&ocular	$126.72
92650	Aep scr auditory potential	N
92651	Aep hearing status deter i&r	$85.56
92652	Aep thrshld est mlt freq i&r	$113.11
92653	Aep neurodiagnostic i&r	$83.29
93241	Ext ecg>48hr<7d rec scan a/r	C
93242	Ext ecg>48hr<7d recording	$14.58
93243	Ext ecg>48hr<7d scan a/r	C
93244	Ext ecg>48hr<7d rev&interpj	$23.33
93245	Ext ecg>7d<15d rec scan a/r	C
93246	Ext ecg>7d<15d recording	$14.58
93247	Ext ecg>7d<15d scan a/r	C
93248	Ext ecg>7d<15d rev&interpj	$25.60
94619	Exercise tst brncspsm wo ecg	$70.00
99417	Prolng off/op e/m ea 15 min	I
99439	Chrnc care mgmt svc ea addl	$35.65
G2170	Avf by tissue w thermal e	C
G2171	Avf use magnetic/art/ven	C
G2211	Complex e/m visit add on	$15.88
G2212	Prolong outpt/office vis	$31.44
G2213	Initiat med assist tx in er	$64.17
G2214	Init/sub psych care m 1st 30	$61.58
G2215	Home supply nasal naloxone	X
G2216	Home supply inject naloxon	X
G2250	Remot img sub by pt, non e/m	$11.67
G2251	Brief chkin, 5-10, non-e/m	$13.61
G2252	Brief chkin by md/qhp, 11-20	$24.95

Sources: *Final 2021 Medicare physician fee schedule, Table 28, placeholder to final code crosswalk and Addendum B*

MDPP

CMS finalizes MDPP changes; program all-virtual until the PHE ends

Changes proposed to sustain the Medicare Diabetes Prevention Program (MDPP) as COVID-19 distancing makes in-person sessions problematic are implemented in the new physician fee schedule final rule — but note some rule changes for participants who start after Jan. 1, 2021.

Suppliers certified to conduct live MDPP services can currently, under an interim rule, either pause a beneficiary's services or switch them to a virtual-only sessions. Note that virtual-only suppliers, who normally step in to provide officially sanctioned "make-up" sessions for missed face-to-face sessions, are not eligible.

Under the final rule, participants who began their course of MDPP — which can last one or two years — before March 31, 2020, can continue with virtual sessions through the end of the PHE. That includes "16 virtual sessions offered weekly during the core session period; six virtual sessions offered monthly during the core maintenance session interval periods; and 12 virtual sessions offered monthly during the ongoing maintenance session interval periods," CMS states in a fact sheet.

Beneficiaries who quit the program during their core sessions but choose to resume it virtually may do so, and even start their program over; however, beneficiaries who suspend their virtual attendance during their maintenance phase will only be allowed to resume it at the point they left off.

The weigh-ins previously required to be done in the presence of the MDPP coach can now be performed virtually via digital technology such as Bluetooth, or via "a participant's own at-home digital scale" with video or other demonstration that the weight was being accurately reported. In the final rule, CMS says it will accept "a photograph of their digital scale" with a time stamp.

Also, while previously the beneficiary had to show a 5% weight loss after the initial core sessions to remain in the program, this requirement will be waived for entrants who begin prior to 2021. Those who start in 2021, however, will need to show the loss. For those interrupting and resuming MDPP sessions, a new starting weight will be taken for comparison purposes.

Though beneficiaries taking virtual sessions can finish their program virtually even if it extends beyond the PHE, the flexibilities will not be extended to entrants starting after the PHE ends. However, MDPP suppliers who can demonstrate a need for "additional time to resume in-person services for reasons related to health, safety, or side availability or suitability" can have a 90-day grace period before switching back to live sessions.

While CMS had proposed extending the engagement incentive period within which suppliers can send a small incentivizing "preventive care item or service," such as a pedometer, to beneficiaries who have not been in contact for 90 days, it has opted to stick with the 90-day limit.
— *Roy Edroso (redroso@decisionhealth.com)* ■