What you need to know: 2021 Medicare Physician Payment Final Rule

In a comprehensive summary, the AMA reviews the key policy changes in the 2021 Medicare Physician Payment Schedule final rule that was released on Dec. 1, including:

- Effective Jan. 1, the Centers for Medicare & Medicaid Services (CMS) will implement the new CPT guidelines to report office and outpatient evaluation and management (E/M) visits based on either medical decision making or physician time and reduce unnecessary documentation. CMS also adopted the AMA/Specialty Society RVS Update Committee (RUC) recommendations for these E/M visits, which will lead to significant payment increases for these services in 2021. Additional resources to get the full benefit of the burden relief from the E/M changes, as well as detailed RUC recommendations, are available at www.ama-assn.org/cpt-office-visits.

- The 2021 Medicare conversion factor, effective Jan. 1, 2021, is $32.6811, which is $3.6811 lower than in 2020. Organized medicine has been advocating to waive the drastic budget neutrality adjustment of -10.2% or at least postpone it during the COVID-19 pandemic given the pandemic's severe negative impact on practice costs and revenue. Please contact your member of Congress and ask them to support the "Holding Providers Harmless from Medicare Cuts During COVID-19 Act" (H.R. 8702).

- CMS finalized its proposals to permanently add several codes to the Medicare telehealth list and certain home visit services. CMS also kept over 150 additional services on the Medicare telehealth list until the end of the calendar year in which the PHE ends to allow more time to study the benefit of providing these services via telehealth.

- CMS did not propose to permanently waive the geographic and originating site limitations on Medicare telehealth services, citing a lack of statutory authority to do so. The AMA strongly supports legislative proposals before Congress that would permanently remove these restrictions and allow telehealth services to be delivered to Medicare patients wherever they are located.

CMS also finalized a number of changes to the Quality Payment Program, such as:

- CMS extended the Merit-based Incentive Payment System (MIPS) Extreme and
Uncontrollable Circumstances Hardship Exception due to COVID-19 through 2021, allowing eligible clinicians to apply to be held harmless from MIPS penalties or to have certain categories reweighted to zero if they experience disruptions related to the public health emergency.

While CMS postponed implementation of MIPS Value Pathways (MVPs) due to the COVID-19 pandemic, the agency finalized that qualified clinical data registries (QCDRs) can support MVPs.

Despite concerns from the AMA and others, CMS finalized an increase in the 2021 MIPS performance threshold from 45 to 60 points to avoid a future penalty.

CMS issues final Hospital Outpatient and ASC Payment Rules for 2021

On Dec. 2, released the 2021 Hospital Outpatient Prospective Payment System (OPPS) final rule, which makes changes to Medicare hospital outpatient and ambulatory surgery center (ASC) policies. The final rule includes a number of significant changes, including:

- Increasing OPPS and ASC payment rates by 2.4% for hospitals and ASCs that meet quality reporting requirements
- Phasing out the inpatient only (IPO) procedure list. Beginning in 2021, CMS will remove approximately 300 primarily musculoskeletal procedures and make them eligible to be paid by Medicare in the hospital outpatient setting when a physician determines outpatient care is medically appropriate. In response to comments from the AMA and others that this would increase physician documentation burden, CMS will exempt these services from certain medical reviews that could result in payment denials when these services are performed on an inpatient basis and the stay does not meet the "2-midnight rule" requirements. The exemption will expire when CMS has sufficient data showing these procedures are more commonly performed in the outpatient setting.
- Adding 278 procedures, including total hip arthroplasty, to the ASC covered procedures list.
- Easing physician-owned hospital restrictions, making it easier for physician-owned hospitals that serve as high Medicaid facilities to expand.
- Changing the minimum default level of supervision for non-surgical extended duration therapeutic services (NSEDTS) to general supervision for the entire service, including the initiation portion of the service, for which Medicare had previously required direct supervision, which the AMA supported.
- Permitting direct supervision of pulmonary rehabilitation, cardiac rehabilitation and intensive cardiac rehabilitation services using virtual presence of the physician through audio/video real-time communications technology subject to the clinical judgment of the supervising physician.

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physician until the later of the end of the calendar year in which the PHE ends or Dec. 31, 2021. The AMA supports this flexibility and believes that the billing physicians must meet all the direct supervision requirements, such as first seeing the patient.

Adding two new categories (cervical fusion with disc removal and implanted spinal neurostimulators) to the list of services requiring prior authorization, despite strong concerns raised by the AMA and other physician organizations. These new requirements are effective for dates of service on or after July 1, 2021; apply only to procedures delivered in hospital outpatient departments; and, while not creating new documentation rules, mandate the submission of supporting clinical information earlier in the process.

Take action: Tell Congress to support H.R. 8702

As physicians continue to battle the worsening COVID-19 pandemic, the last thing they should have to worry about is cuts to their Medicare payments. Unfortunately, without Congressional action before Jan. 1, that nightmare scenario will become reality. Under current law CMS is required to make budget neutrality adjustments to the Medicare physician payment schedule whenever changes in relative value units (RVU) generates a payment increase or decrease by $200 million.

As a result, significant increases in RVUs for office evaluation and management (E/M) services finalized by CMS this month and scheduled to take effect in 2021 will lead to a wide range of payment increases and decreases based on the mix of services each specialty provides. Unfortunately, there is broad consensus that these adjustments will compound the COVID-19 pandemic's negative impact on physician practices and further aggravate concerns about the viability of independent practices. Budget neutrality requirements will lead to lower payments for a multitude of services crucial to combatting the pandemic, including hospital visits, critical care visits, nursing home visits and home visits.

In late October, Reps. Ami Bera, MD (D-CA) and Larry Bucshon, MD (R-IN) introduced bipartisan legislation to address these concerns. The "Holding Providers Harmless from Medicare Cuts During COVID-19 Act" (H.R. 8702) would freeze payments at 2020 rates for services scheduled to be cut in 2021 for a period of two years, while allowing the scheduled E/M increases to take place. Analyses of this approach show improved overall impact numbers for all physician specialties.

If Congress does not act NOW, these budget neutrality adjustments will negatively impact many physician practices across the country.


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Please contact your member of Congress, ask them to support the "Holding Providers Harmless from Medicare Cuts During COVID-19 Act" (H.R. 8702), and request the bill's inclusion in a larger, end-of-the-year legislative package today.

CMS extends 2020 MIPS hardship deadline to Feb. 1, 2021

In response to AMA advocacy efforts, CMS recently announced an extension of the 2020 hardship exception application deadline until Feb. 1, 2021. However, the deadline for the Promoting Interoperability Hardship Exception application will remain Dec. 31. If you are already exempt from reporting Promoting Interoperability data, you do not need to apply.

CMS recognizes the COVID-19 pandemic has impacted all clinicians across the United States and for the 2020 MIPS performance year, CMS will be using the Extreme and Uncontrollable Circumstances policy to allow clinicians, groups and virtual groups to submit an application requesting reweighting of one or all MIPS performance categories due to the current COVID-19 pandemic PHE. The AMA recommends applying for a hardship exception if your practice experienced disruptions due to COVID-19 in 2020. At a minimum, the AMA suggests physicians apply to have the cost performance category re-weighted to 0% of the final score due to significant changes in care delivery and resource use during the PHE. Physicians who do not file a hardship will be subject to a 2022 MIPS payment adjustment.

To assist physicians with understanding how to apply for a 2020 MIPS Hardship due to COVID-19 PHE, CMS recently recorded a video demonstrating how the 2020 MIPS Hardship Application process works. Submit an application now and be sure to cite COVID-19 as the reason for your application.

AMA urges further research into cannabis products prior to legalization efforts

The AMA sent a letter to House Speaker Nancy Pelosi and House Minority leader Kevin McCarthy expressing significant concerns about H.R. 3884 the "Marijuana Opportunity Reinvestment and Expungement (MORE) Act of 2019." The MORE Act would decriminalize marijuana and expunge convictions for marijuana-related offenses, among many other provisions. The AMA does not support legalizing cannabis use until further research is completed on the public health, medical, economic and social consequences of its use. As such, the AMA strongly supports S. 2032, the "Cannabidiol and Marijuana Research Expansion Act" which would improve the process for conducting scientific research.
and clinical research on cannabidiol (CBD) and marijuana, and streamline the development of safe and effective cannabinoid-based drugs approved by the FDA.

The AMA is very concerned with the growing public support and legislative efforts at all levels of government to legalize marijuana and the medical use of cannabis. This has resulted in many individuals using marijuana-derived products that have not been approved by the FDA. The AMA believes that scientifically valid and well-controlled clinical trials conducted under federal investigational new drug applications are necessary to assess the safety and effectiveness of all new drugs including potential cannabis products for medical use. Cannabis and its compounds, in particular CBD, has been found to have some therapeutic benefits. However, legal and regulatory barriers to cannabis and cannabinoid research have left physicians and patients without the evidence needed to understand the health effects of these products and make sound clinical decisions regarding their use. Federal efforts should focus on removing barriers to research.

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