

# Final 2021 Medicare pay schedule: What physicians need to know

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The 2021 Medicare physician payment schedule finalized an AMA-developed approach for less burdensome coding and documenting of office and outpatient evaluation and management (E/M) services.

The Centers for Medicare & Medicaid Services (CMS) also extended Medicare payment for many services delivered via telehealth at least until the end of calendar year 2021, but indicated that it does not have authority to adopt AMA recommendations to continue to allow telehealth to be provided outside of rural areas or for patients to continue receiving telehealth services in their homes beyond the declared Public Health Emergency (PHE).

Read the AMA's summary of 2021 Medicare Physician Payment Schedule and Quality Payment Program for an in-depth look at the major elements of CMS' final rule.

The changes coming Jan. 1 regarding E/M office-visit services are "foundational improvements," AMA President Susan R. Bailey, MD, said. They are also in line with recommendations from the Current Procedural Terminology (CPT<sup>®</sup>) Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC).

But CMS said that, by law, it must offset newly adopted office-visit pay rates with pay cuts to other Medicare services to achieve budget neutrality.

## Legislative fix needed

The AMA sent detailed comments to CMS when the proposed schedule was released in August and urged the agency to use its authority to waive the budget-neutrality requirements and avert the cuts that will be deeply problematic for physician practices that have experienced severe reductions in

revenue during the pandemic.

CMS projects \$9.9 billion in new spending to growth that must be offset. The spending growth includes:

- \$5.6 billion generated by the E/M reforms.
- \$3 billion created by a CMS-developed office-visit complexity add-on code, G2211.
- \$1.3 billion spawned by revaluation of other services and payments, including end-stage renal disease monthly capitated payments, transitional care management, and cognitive impairment assessment.

CMS will implement a drastic 10.2% reduction in the Medicare conversion factor that will cause a significant redistribution of payment starting Jan. 1. CMS estimates that the impact on different medical specialties will range from a drop of 10% to an increase of 16% depending on the mix of services provided.

The AMA is advocating that Congress pass H.R. 8702, the Holding Harmless from Medicare Cuts During COVID-19 Act of 2020, introduced by a bipartisan pair of physician legislators: Reps. Ami Bera, MD, a California Democrat, and Larry Bucshon, MD, a Republican from Indiana.

The AMA Physicians Grassroots Network has been activated to build support for the bill, which would effectively freeze payments for a two-year period at 2020 rates for services scheduled to be cut in 2021, while allowing the larger E/M payments to go forward. It would also avert steep payment cuts for hospital, nursing home, emergency department and critical care visits. At the end of the two-year reprieve, the full budget-neutrality adjustment would take effect.

## Telehealth advocacy

Earlier this year, the Coronavirus Aid, Relief and Economic Security (CARES) Act enacted a general waiver provision enabling the Department of Health and Human Services (HHS) to temporarily lift outdated originating site and geographic restrictions on Medicare's coverage of telehealth-enabled services.

CMS immediately acted to facilitate broad patient access to telehealth across the country and to patients in their homes. It added numerous services to the list of those Medicare covers when provided via telehealth and increased payments for telehealth services to be the same as in-person services. It also began covering the CPT codes for telephone visits, which has allowed provision of audio-only services.

Previously, physicians were prohibited from offering most Medicare telehealth services outside of rural areas, and Medicare patients in rural areas were not able to receive most of those services unless they traveled to a health care facility. The AMA recommended that these and other changes be made permanent, but the agency said this was beyond its authority and only extended the changes for the duration of the PHE.

The AMA Physicians Grassroots Network has called on Congress to permanently lift the geographic and site restrictions on telehealth technologies so all Medicare beneficiaries have access to the services.

The AMA is supporting S. 4375, the “Telehealth Modernization Act of 2020,” which would permanently remove the rural-only restriction and add any site where a patient is located as a potential originating site, ensuring all Medicare beneficiaries may receive covered Medicare telehealth benefits, including at home and via mobile technologies as appropriate.

CMS also declined to continue payments for audio-only patient visits beyond the PHE.

CMS did, however, take several actions aimed at maintaining the momentum behind telehealth growth and the use of digital health tools. More than 150 codes have been added to the CMS Telehealth List.

Some added services will be permanent, others will be removed when the PHE ends, and others will be kept on through the calendar year of whenever the PHE ends. It finalized many care-management services and remote physiologic-monitoring services—though, after the PHE, this will be maintained only for established, not new, patients.

Similarly, CMS extended the policy for allowing teaching physicians to bill for supervision of residents using two-way audio-visual communication until the end of the PHE, and only making it permanent for residency training sites in rural areas.

Regarding lifestyle-change Medicare Diabetes Prevention Programs (MDPPs), CMS allowed Medicare beneficiaries who start virtual programs during the PHE and continue them to their conclusion virtually even after the PHE concludes. The agency also made permanent the option to do so for future emergencies when in-person services are not possible.

CMS also changed its rule so certain beneficiaries will be able to be covered for MDPP services more than once in their lifetime.

## Quality payment provisions

Regarding the Medicare Quality Payment Program, CMS actions noted in the massive 2,165-page payment-schedule document included:

- Extending the Extreme and Uncontrollable Circumstances Hardship Exception due to COVID-19 through 2021, which allows eligible clinicians to apply to be held harmless from Merit-based Incentive Payment System (MIPS) or to have certain categories reweighted to zero if they experience disruptions related to the PHE.
- Postponing implementation of its MIPS Value Pathways (MVP) until the 2022 performance period. The goal behind MVPs is to reduce the complexity and administrative burdens associated with MIPS and to develop a program that is more aligned with a physician's specialty.
- Increasing the performance threshold to avoid a penalty to 60 points in 2021 from 45 points in 2020.

## Other key elements

CMS expanded bundled payment codes used to report monthly treatment of patients with opioid-use disorder (OUD) to cover treatment for any substance-use disorder. It also will now allow opioid-treatment programs to be paid for dispensing naloxone to patients receiving OUD-treatment services.

To address the financial impact of additional supplies and new staff activities required to maintain safe patient care during the pandemic, the CPT Editorial Panel approved CPT code 99072. AMA and other groups in organized medicine advocated for CMS to immediately pay for CPT code 99072—with no patient cost sharing—using money that remained in the CARES Act Provider Relief Fund.

Instead, CMS is finalizing CPT code 99072 as a bundled service on an interim basis. It also finalized on an interim basis price increases on masks and other personal protection equipment to be bundled into office-based procedure codes.