SALIENT HEALTHCARE
A Division of Salient Management Company

2021 MPFS and QPP Final Rule: Summary of Rules Impacting Value-Based Organizations

On December 1, 2020, the Centers for Medicare & Medicaid Services (CMS) published the Calendar Year (CY) 2021 Final Rule for the Medicare Physician Fee Schedule. It became effective as of January 1, 2021. Below is a summary of the final rules that impacting value-based organizations.

Significant Updates to the Quality Payment Program (QPP)

For Performance Year 2020, CMS will provide Accountable Care Organizations full credit on the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, given the impact of the pandemic.

Starting in 2021, the quality reporting requirements will align with the Meaningful Measures to reduce the reporting burden for ACOs. Moving forward, organizations will have a quality measure set that consists of three eCQM/MIPS CQM/Medicare Part B Claims measures, a CAHPS for MIPS Survey measure, and two measures that will be calculated by CMS using administrative claims data. However, for the 2021 performance period only, participants in ACOs can select either to report on the 10 CMS Web Interface measures or the three eCQM/MIPS CQM/Medicare Part B claims measures. The CMS Web Interface will sunset with the 2022 performance period.

Reimbursement Changes

Physician Fee Schedule Decreased Conversion Factor (CF)
The final CY 2021 PFS conversion factor is $32.41, a decrease of $3.68 from the CY 2020 PFS conversion factor of $36.09—or 10%. Overall, this will impact specialists, as they will see a pay cut, including radiology (-10%), chiropractor (-10%), nurse anesthetist (-10%) and physical and occupational therapy (-9%).[1] Three levels of new patient E/M visits will also experience a decrease:

E/M office visit fee comparison, 2020-2021

Code	2020 Total RVUs	2020 CF	2020 Fee	2021 Total RVUs	2021 CF	2021 Fee	YTY Fee Change
99202	2.14	$36.09	$77.23	2.14	$32.41	$69.35	-$7.88
99203	3.03	$36.09	$109.35	3.29	$32.41	$106.62	-$2.73
99204	4.63	$36.09	$167.09	4.94	$32.41	$160.10	-$7.00
99205	5.85	$36.09	$211.12	6.53	$32.41	$211.63	$0.50
99211	0.65	$36.09	$23.46	0.69	$32.41	$22.36	-$1.10
99212	1.28	$36.09	$46.19	1.68	$32.41	$54.45	$8.25
99213	2.11	$36.09	$76.15	2.69	$32.41	$87.18	$11.03
99214	3.06	$36.09	$110.43	3.81	$32.41	$123.48	$13.04
99215	4.11	$36.09	$148.33	5.34	$32.41	$173.06	$24.73

[1] https://pbn.decisionhealth.com/Blogs/Detail.aspx?id=200935

Permanent Telehealth Service Additions
As part of the ongoing expansion of telehealth services, CMS is adding the following services to the Medicare telehealth list:

- Group Psychotherapy (CPT Code 90853)
- Psychological and Neuropsychological Testing (CPT Code 96121)
- 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 Evaluation and Management (E/M) (HCPCS Code G2211)
- Prolonged Services (HCPCS Code G2212)

Care Management Services

Minor changes to TCM and CCM concurrent billing
There is a list of 57 codes that cannot be billed concurrently with 99495 and 99496 because of those services' potential duplication- 14 codes have been removed from that list for 2021.

PCM Billing for RHCs and FQHCs
In the CY 2020 PFS final rule, separate payment was established for Principal Care Management (PCM) services (G2064 and G2065). G0511 will be used for PCM services furnished in RHCs and FQHCs beginning January 1, 2021.

Updates for Remote Physiologic Monitoring (RPM) Services
There is a specific list of clarifications, so without interpretation, here it is, directly from CMS:

- "We clarified that after the COVID-19 PHE ends, there must be an established patient-physician relationship for RPM services to be furnished.
- We finalized that consent to receive RPM services may be obtained at the time that RPM services are furnished.
- We finalized that auxiliary personnel may provide services described by CPT codes 99453 and 99454 incident to the billing practitioner's services and under their supervision. Auxiliary personnel may include contracted employees.
- We clarified that the medical device supplied to a patient as part of RPM services must be a medical device as defined by Section 201(h) of the Federal Food, Drug, and Cosmetic Act, that the device must be reliable and valid, and that the data must be electronically (i.e., automatically) collected and transmitted rather than self-reported.
- We clarified that after the COVID-19 PHE ends, 16 days of data each 30 days must be collected and transmitted to meet the requirements to bill CPT codes 99453 and 99454.
- We clarified that only physicians and NPPs who are eligible to furnish E/M services may bill RPM services.
- We clarified that RPM services may be medically necessary for patients with acute conditions as well as patients with chronic conditions.
- We clarified that for CPT codes 99457 and 99458, an "interactive communication" is a conversation that occurs in real-time and includes synchronous, two-way interactions that can be enhanced with video or other kinds of data as described by HCPCS code G2012. We further clarified that the 20-minutes of time required to bill for the services of CPT codes 99457 and 99458 can include time for furnishing care management services as well as for the required interactive communication."[2]

[2] https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1