2021 Physician Fee Schedule Final Rule: Significant Changes for Physician Practices

December 03, 2020

On December 1, 2020, the Centers for Medicare and Medicaid Services issued the calendar year 2021 Medicare Physician Fee Schedule final rule reflecting policy changes impacting Medicare reimbursement. Most provisions contained in the rule are effective January 1, 2021. These updates reflect the most substantial changes in many years, which will have a significant impact on physician practice revenue. Furthermore, the changes will impact physician compensation under commonly used production-based compensation models. The impact will vary based on specialty, service mix, payer mix, and other factors, but all physician practice organizations should plan for changes.

Background

Each year, the Centers for Medicare and Medicaid Services ("CMS") reviews the listing of Current Procedural Terminology ("CPT") codes that are used for billing professional medical services. Often, new codes are added to reflect new or modified services, or codes may be removed from the list if they are no longer deemed necessary. As part of this review process, CMS considers whether any changes should be made with regard to the Relative Value Units ("RVU") associated with each CPT code, including the Work RVU ("wRVU") component, which is intended to reflect the time and complexity to perform the service.

In 2017, CMS launched the "Patients over Paperwork" initiative, with the goal of eliminating unnecessary or burdensome regulations. The overarching objective of this initiative was to encourage innovation and allow providers to focus their efforts on meeting the needs of their patients. One component of this initiative was to study the appropriateness of the RVU values associated with new and established office visit CPT codes. This involved, among other things, a time study that indicated that providers are spending more time on each patient visit than they did a few years ago. The increase reflects a combination of increased time with the patient, time associated with required documentation in electronic medical record ("EMR") systems, and time associated with coordinating care with other providers and/or managing chronic conditions.

The press release (https://web.archive.org/web/20210116230233/https://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment)[1] issued by CMS

notes that increasing the payment rate for office evaluation and management ("E&M") visits recognizes the increasing demand for these services resulting from growth in the number of Medicare beneficiaries and increased complexity of their healthcare needs given the high frequency of chronic conditions and ensures that providers are paid appropriately for the time spent caring for patients.

Given the high frequency of office E&M visits, which CMS indicates account for around 20% of total allowed charges for physician services, any changes to wRVU values associated with these codes will have a significant impact on reimbursement for these professional services and potentially physician compensation, if all or part is based on productivity.

2021 E&M Changes

As a result of its in-depth assessment, CMS proposed significant changes to the office/outpatient E&M codes, which were finalized in the Calendar Year 2019 Physician Fee Schedule ("PFS") Final Rule[2] with an effective date of January 1, 2021, and affirmed in the CY 2021 PFS Final Rule. In connection with the increased wRVU values for each CPT code, CMS increased the total time attributed to each visit. The changes are summarized in the table that follows:

CPT		Description	Current Minimum Minutes Per Visit	Current wRVU	2021 Minimum Minutes Per Visit	2021 wRVU	% Variance in wRVUs
99201	New Patients	Level 1	17	0.48	N/A - Code Eliminated		
99202		Level 2	22	0.93	22	0.93	0.0%
99203		Level 3	29	1.42	40	1.60	12.7%
99204		Level 4	45	2.43	60	2.60	7.0%
99205		Level 5	67	3.17	85	3.50	10.4%
99211	Established Patients	Level 1	7	0.18	7	0.18	0.0%
99212		Level 2	16	0.48	18	0.70	45.8%
99213		Level 3	23	0.97	30	1.30	34.0%
99214		Level 4	40	1.50	49	1.92	28.0%
99215		Level 5	55	2.11	70	2.80	32.7%
G2212		Prolonged Visit	N/A	N/A	15	0.61	N/A
G2211		Visit Complexity Add-On	N/A	N/A	11	0.33	N/A

As noted in the table above, CPT Code 99201 for a Level 1 new patient visit will be eliminated. Providers will select the appropriate CPT code based on either time or medical decision making, at the discretion of the provider. Additionally, a new code for prolonged visits (G2212, to be used in place of CPT Code 99417, which was referred to as 99XXX in the CY 2021 PFS Proposed Rule) was established to be billed as an add-on to 99205 or 99215 for extra 15-minute increments beyond the standard time for a such visit. However, to address potential inconsistency of the CMS reimbursement policy with this code, the Final Rule established new HCPCS code (G2212) to be used when billing Medicare for prolonged services instead of 99417. Finally, another new code (G2211, referred to in the Proposed Rule as GPC1X) will be used to bill for visit complexity in applicable circumstances.

In addition to affirming the changes to E&M codes finalized previously, the CY 2021 PFS Final Rule also finalized revisions to certain global CPT codes that include an expected number of office visits. Notably, this includes codes relating to maternity care, end-stage renal disease, and certain codes related to assessment and care planning for patients with cognitive impairment. Additionally, to retain alignment with outpatient E&M wRVU values, the 2021 Final Rule includes increases to Emergency Department E&M codes as well as therapy evaluation codes. The affected CPT codes and the corresponding wRVU values are summarized in Exhibit A.

2021 Conversion Factor Changes

Medicare reimbursement for professional services is generally determined by multiplying the applicable RVU amounts for billed services by the conversion factor in place on the date the service was rendered (adjusted for the specific locality). In

response to the significant increases to E&M wRVUs, the 2021 PFS Final Rule includes reductions in both the Conversion Factor and the Anesthesia Conversion Factor, based on budget neutrality requirements. While the final rates are slightly higher than those reflected in the Proposed Rule, it is still a substantial reduction from current rates, as shown below:

	2020	2021	% Change
Conversion Factor	$36.09	$32.41	(10.2%)
Anesthesia Conversion Factor	$22.20	$20.05	(9.7%)

This reduction will have a dramatic impact on all medical practices, though some specialties will be impacted more than others. For primary care and other specialties with a high number of office visits (such as endocrinology and rheumatology), the increase in E&M wRVUs may substantially offset the decreased Conversion Factor, depending upon practice patterns and payer mix. However, specialties that have a higher percentage of activity in procedural codes and fewer office visits will likely experience a significant decline in Medicare reimbursement, as the Conversion Factor will apply to all services billed, not just E&Ms.

Physician Compensation Considerations

While the 2021 PFS Final Rule only impacts the reimbursement side of the equation for medical practices, it is worth noting that many employed physicians are compensated at least in part based on wRVU production. Given the substantial changes in wRVUs that will be effective in 2021, physician compensation will be directly impacted. For those specialties with high-volume office visits, volumes consistent with prior years will result in increased wRVUs, which could then substantially increase physician compensation depending on the structure of the compensation arrangement. Even without factoring in the decreased Conversion Factor, practices must consider whether the level of increase in compensation resulting from the revised wRVUs is warranted, and whether such amounts would be considered commercially reasonable in comparison to historical compensation levels and market benchmarks. Again, this issue is exacerbated by the reduced conversion factor that is expected to result in overall lower reimbursement for many specialties. Therefore, practices may be faced with significantly increased compensation at the same time they experience reduced revenue for the same volume and mix of services as prior years. Unchecked, this could result in significant practice losses. Accordingly, practices must consider whether changes to physician compensation structures and/or rates will be necessary to remain economically viable and avoid regulatory compliance violations.

Telehealth Services

The Final Rule added several services to the Medicare Telehealth List on a Category 1 basis, with means they are similar to services already on the telehealth list. These are considered permanent additions. Category 2 includes services that are not similar to services already on the telehealth list. The Final Rule also created Category 3, which includes services added to the Medicare Telehealth List only during the public health emergency (PHE). These services will remain on the list through the calendar year in which the PHE ends or December 31, 2021, whichever is later.

Telehealth services permanently added to the list include the following:

- 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

Temporary services (Category 3) finalized in the Final Rule include the following, some of which were not reflected in the Proposed Rule (these are indicated in bold):

- Domiciliary, Rest Home, or Custodial Care Services, established patients (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 and 96136-96139)
- Therapy Services, Physical & Occupational Therapy, all levels (CPT 97161-97168, 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 99521-99524, & 92507)
- Hospital discharge day management (CPT 99238-99239)
- Inpatient Neonatal & Pediatric Critical Care, Subsequent (CPT 99469, 99472, & 99476)
- Continuing NICU Services (CPT 99478-99480)
- Critical Care Services (CPT 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, & 90962)
- Subsequent Observation & Observation Discharge Day Management (CPT 99217 and 99224-99226)

Notably, the Final Rule also addresses services that are intentionally NOT being added to the telehealth list on either a permanent or temporary basis. These primarily include initial visits (nursing facility, hospital care, home visits, NICU and PICU, etc.). CMS noted concerns regarding the risk of patient harm resulting from the lack of an in-person physical exam for the provider to fully understand the health status of the patient. Additionally, the Final Rule noted that audio-only assessment and management of E&M visits do not meet the regulatory interpretation of "telecommunications system" for the purpose of Medicare telehealth services, and thus reimbursement for such services will not be provided once the PHE related to COVID-19 expires. However, HCPCS code G2252 is being added for CY 2021 for a "virtual check-in" by a physician or other qualified healthcare professional with an established patient (11-20 minutes of medical discussion) to determine whether an in-person visit is warranted.

CMS also finalized its proposed clarification that telehealth services can be furnished and billed when provided incident to a "distant site" physician's service so long as direct supervision is provided using real-time audio and video technology. This provision will run through the end of the calendar year when the current PHE ends or December 31, 2021, whichever is later.

Other Updates

Supervision of Diagnostic Tests

CMS finalized proposed rules to permanently allow nurse practitioners, clinical nurse specialists, physician assistance, and certified nurse midwives to supervise certain diagnostic tests, to the extent such services are within their scope of practice and applicable state laws. Additionally, the Final Rule added certified registered nurse anesthetists to the list of approved providers.

Immunization Services

Noting the importance of ensuring beneficiary access to vaccinations, particularly during the current PHE, CMS finalized a policy to maintain the CY 2019 payment for CPT codes 90460, 90471 and 90473 and HCPCS codes G0008, G0009, and G0010

as well as the add-on CPT codes 90461, 90472, and 90474. This was done to address concerns regarding the reductions in payment rates for vaccine administration services over a multi-year period. CMS plans to review resource-based valuations for these services in the future, recognizing the importance of maintaining high immunization rates for public health purposes.

Use of Therapy Assistants

The Final Rule allows physical therapists and occupational therapists that have established a therapy maintenance program for a patient to delegate maintenance therapy services to therapy assistants when clinically appropriate. This rule expires at the end of the PHE for COVID-19.

Medical Record Documentation

The Final Rule clarifies that providers may review and verify (i.e., sign and date) medical records for services they bill rather than being required to re-document notes made by other members of the medical team. Further, the rule clarifies that students (including therapy students and students of other disciplines), may document the medical record so long as the documentation is reviewed and verified by the billing provider.

Clinical Lab Fee Schedule

In recent years, the payment for clinical diagnostic laboratory tests has undergone significant changes. The payment amount for each test on the Clinical Laboratory Fee Schedule is based on certain private payor rate information reporting entities are required to provide to CMS. A phase-in of payment reductions was implemented, limiting the amount that the reimbursement rate for each test may be reduced in comparison to the rate for the prior year. The CARES Act revised the reporting requirements to delay the next reporting period so that no reporting is required from January 1, 2020 through December 31, 2021. Reporting would be required during the period January 1, 2022 through March 31, 2022 and every three years thereafter. The CY 2021 PFS Final Rule clarifies that the data collection period for the 2022 reporting period will be January 1, 2019 through June 30, 2019. Further, it states that the payment amount for a clinical diagnostic laboratory test in 2021 cannot be lower than the payment for the same test in 2020 (i.e., 0% reduction factor).

RHCs and FQHCs

Principal Care Management (PCM) services include comprehensive care management services for a single high-risk disease or complex condition typically expected to last at least three months. Beginning in 2020, providers could bill for PCM services using two new HCPCS codes, G2064 (for services provided by physicians) and G2065 (for services provided by clinical staff under the direction of a physician or non-physician provider). However, these services did not meet the requirements for an RHC or FQHC billable visits. In the Final Rule, these two HCPCS codes are added to the general care management code (G0511) as a comprehensive care management service for Rural Health Clinics and Federally Qualified Health Clinics starting January 1, 2021. When RHCs and FQHCs provide PCM services, they will be able to bill the services using HCPCS code G0511, either alone or with other payable services. The payment rate will be the average of the national non-facility physician fee schedule payment rates for the RHC/FQHC care management and general behavioral health codes, with the addition of HCPCS G2064 and G2065. In other words, the PCM services will be added to G0511 to determine a new national average for the non-facility payment rate. The rate will be updated annually.

Medicare Shared Savings Program

The Final Rule provides automatic full credit for CAHPS® patient experience of care surveys for performance year 2020. CMS also finalized several changes in how beneficiaries are assigned to Accountable Care Organizations (ACOs) and adopted policies to reduce the burden associated with repayment mechanisms.

What's Next?

Two bills have been introduced in Congress to address the budget neutrality adjustments reflected in the CY 2021 Physician Fee Schedule. H.R. 8505 seeks to delay the budget neutrality adjustments for one year, while H.R. 8702 proposed that cuts to provider reimbursement be offset by providing add-on payments to affected services for two years, with such payments equal to the difference between the 2020 and 2021 reimbursement amounts for the applicable CPT codes (excluding certain E&M codes which have RVU increases in 2021). Both bills were referred to committees in October but have seen no further action. While legislative action is possible, physician organizations should assume until further notice that the reimbursement rates reflected in the CY 2021 Physician Fee Schedule Final Rule will stand.

If they have not done so already, physician practice organizations should engage either internal or external resources to perform the following:

1. Discretely calculate the expected wRVUs for each provider;
2. Model the expected revenue impact, by provider, of the proposed changes;
3. Model the expected physician compensation impact, based on current contract terms applicable to 2021; and
4. Determine potential revisions to provider contracts that might be required to maintain commercial reasonability and/or financial feasibility for the practice.

Many organizations are choosing to adopt the 2020 Physician Fee Schedule for purposes of physician compensation plans in 2021 to avoid (or delay) the significant physician compensation increases likely to result from the wRVU changes, but this likely involves amending the affected physician contracts if the contract language (and/or historical practice) utilizes current Medicare fee schedules. It will be important to collaborate with legal counsel regarding any contemplated changes to physician compensation terms to ensure regulatory compliance. Organizations will need to develop a plan for communicating with providers and rolling out any necessary changes.

In addition to considering necessary changes to physician compensation terms, practices should also determine the potential impact for managed care payers. It will be important to identify which payer fee schedules are based on Medicare and develop a strategy for renegotiating contracts as deemed necessary to optimize the revenue stream for the practice.

JTaylor has a team of professionals dedicated to helping practices analyze the impact of these proposed changes. We can help you develop an effective strategy to mitigate the impact and ensure that your organization is positioned to be financially viable once the CMS changes are implemented.

Additional Resources

Fact Sheet: www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1 (https://web.archive.org/web/20210116230233/https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1)

Final Rule: www.federalregister.gov/public-inspection/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part (https://web.archive.org/web/20210116230233/https://www.federalregister.gov/public-inspection/2020-26815/medicare-program-cy-2021-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part)

Exhibit A

Services with Revised wRVUs

CPT	Description	Current wRVU	2021 wRVU	% Variance in wRVUs
59400	Routine OB care including antepartum care, vaginal delivery, & postpartum care	32.16	36.58	13.7%
59410	Vaginal delivery only, including postpartum care	18.01	18.34	1.8%
59425	Antepartum care only, 4-6 visits	6.31	7.80	23.6%
59426	Antepartum care only, 7 or more visits	11.16	14.30	28.1%
59430	Postpartum care only (separate procedure)	2.47	3.22	30.4%
59510	Routine OB care including antepartum care, cesarean delivery, & postpartum care	35.64	40.39	13.3%
59515	Cesarean delivery only; including postpartum care	21.47	22.13	3.1%
59610	Routine OB care including antepartum care, vaginal delivery, and postpartum care after previous cesarean delivery	33.87	38.29	13.0%
59614	Vaginal delivery only, after previous cesarean delivery, including postpartum care	19.73	20.06	1.7%
59618	Routine OB care including antepartum care, cesarean delivery, and postpartum care, following attempted vaginal delivery after previous cesarean delivery	36.16	40.91	13.1%
59622	Cesarean delivery only; following attempted vaginal delivery after previous cesarean delivery, including postpartum care	22.00	22.66	3.0%
90791	Psychiatric diagnostic evaluation	3.00	3.84	28.0%
90792	Psychiatric diagnostic evaluation with medical services	3.25	4.16	28.0%
90832	Psychotherapy, 30 minutes with patient	1.50	1.70	13.3%
90834	Psychotherapy, 45 minutes with patient	2.00	2.24	12.0%
90837	Psychotherapy, 60 minutes with patient	3.00	3.31	10.3%
90951	ESRD services monthly, for patients younger than 2, with 4 or more face-to-face visits per month	18.46	23.92	29.6%
90954	ESRD services monthly, for patients 2-11, with 4 or more face-to-face visits per month	15.98	15.98	0.0%
90955	ESRD services monthly, for patients 2-11, with 2-3 face-to-face visits per month	8.79	10.32	17.4%
90956	ESRD services monthly, for patients 2-11, with 1 face-to-face visit per month	5.95	6.64	11.6%
90957	ESRD services monthly, for patients 12-19, with 4 or more face-to-face visits per month	12.52	15.46	23.5%
90958	ESRD services monthly, for patients 12-19, with 2-3 face-to-face visits per month	8.34	9.87	18.3%
90959	ESRD services monthly, for patients 12-19, with 1 face-to-face visit per month	5.50	6.19	12.5%
90960	ESRD services monthly, for patients 20 or older, with 4 or more face-to-face visits per month	5.18	6.77	30.7%
90961	ESRD services monthly, for patients 20 or older, with 2-3 face-to-face visits per month	4.26	5.52	29.6%
90962	ESRD services monthly, for patients 20 or older, with 1 face-to-face visit per month	3.15	3.57	13.3%
90963	ESRD services for home dialysis per month, for patients younger than 2	10.56	12.09	14.5%
90964	ESRD services for home dialysis per month, for patients 2-11	9.14	10.25	12.1%
90965	ESRD services for home dialysis per month, for patients 12-19	8.69	9.80	12.8%
90966	ESRD services for home dialysis per month, for patients 20 and older	4.26	5.52	29.6%
90968	ESRD services for dialysis less than a full month of service, per day, for patients 2-11	0.30	0.34	13.3%
90969	ESRD services for dialysis less than a full month of service, per day, for patients 12-19	0.29	0.33	13.8%
90970	ESRD services for dialysis less than a full month of service, per day, for patients 20 and older	0.14	0.18	28.6%
92521	Evaluation of speech fluency	1.75	2.24	28.0%
92522	Evaluation of speech sound production	1.50	1.92	28.0%
92523	Evaluation of speech sound production with evaluation of language comprehension & expression	3.00	3.84	28.0%
92524	Behavioral and qualitative analysis of voice and resonance	1.50	1.92	28.0%
97161	Physical therapy evaluation, low complexity (typically 20 minutes)	1.20	1.54	28.3%
97162	Physical therapy evaluation, moderate complexity (typically 30 minutes)	1.20	1.54	28.3%
97163	Physical therapy evaluation, high complexity (typically 45 minutes)	1.20	1.54	28.3%
97164	Re-evaluation of PT established plan of care (typically 20 minutes)	0.75	0.96	28.0%
97165	Occupational therapy evaluation, low complexity (typically 30 minutes)	1.20	1.54	28.3%
97166	OT evaluation, moderate complexity (typically 45 minutes)	1.20	1.54	28.3%
97167	OT evaluation, high complexity (typically 60 minutes)	1.20	1.54	28.3%
97168	Re-evaluation of OT established plan of care (typically 30 minutes)	0.75	0.96	28.0%
99283	ED visit, moderate severity	1.42	1.60	12.7%
99284	ED visit, high severity but not immediate significant threat to life	2.60	2.74	5.4%
99285	ED visit, high severity, immediate significant threat to life	3.80	4.00	5.3%
99483	Assessment of & care planning for patient with cognitive impairment, inclusive of all required elements	3.44	3.80	10.5%
99492	Initial psychiatric collaborative care management, first 70 minutes in the first calendar month	1.70	1.88	10.6%
99493	Subsequent psychiatric collaborative care management, first 60 minutes in a subsequent month	1.53	2.05	34.0%
99495	Transitional Care Management services (including face-to-face visit within 14 calendar days of discharge)	2.36	2.78	17.8%
99496	Transitional Care Management services (including face-to-face visit within 7 calendar days of discharge)	3.10	3.79	22.3%
G0402	Initial preventative physical exam	2.43	2.60	7.0%
G0438	Annual wellness visit, initial visit	2.43	2.60	7.0%
G0439	Annual wellness visit, subsequent visit	1.50	1.92	28.0%

Codes and corresponding Current and 2021 wRVUs obtained from Tables 23 and 25 of the CY 2021 Physician Fee Schedule Final Rule. Descriptions have been abbreviated.

Endnotes

[1] Center for Medicare & Medicaid Services. (2020, Dec 1). *Trump Administration Finalizes Permanent Expansion of Medicare Telehealth Services and Improved Payment for Time Doctors Spend with Patients* [Press release]. www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment (https://web.archive.org/web/20210116230233/http://www.cms.gov/newsroom/press-releases/trump-administration-finalizes-permanent-expansion-medicare-telehealth-services-and-improved-payment)

[2] 84 FR 62468

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- Contact (/web/20210116230233/https://www.jtaylor.com/contact/)
- Client Login (/web/20210116230233/https://www.jtaylor.com/client/)
- Secure File Transfer (https://web.archive.org/web/20210116230233/http://jtallc.leapfile.net/)

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