Summation 2021 Final Rule Medicare Physician Fee Schedule, Hospital Outpatient Prospective Payment System and MIPS

December 9, 2020

Table of Contents

Summation 2021 Final Rule Medicare Physician Fee Schedule

Payments

The Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Final Rule on Tuesday, December 1, 2020. The information contained goes into effect on January 1, 2021. The information below highlights areas that will be of interest to those in the radiation oncology specialty. Per the rates set in this Final Rule, radiation oncology will see decreases in payments from both the conversion factor and changes in RVU's.

CY 2021 includes an increase in RVU's resulting in an increase in payment for E/M procedures, which then necessitates a budget neutrality adjustment that is required by law. This budget neutrality adjustment lowers the conversion factor from $36.09 in CY 2020 to $32.41 in CY 2021. This is a decrease of $3.68. While the increase in payment for the E/M codes will benefit primary care physicians and many specialties due to their utilization of E/M codes, this will be detrimental to radiation oncologists.

The reductions of the Conversion Factor and RVU's was calculated across a range of our billing clients with the following outcomes detailed below. These numbers are exactly why all radiation oncologists must work individually with their local congressman and legislatures, and partner with ASTRO in any movements they are undertaking.

Professional Groups – Est. to lose 7-10% (Avg. 9% loss)

- In dollars, the losses ranged between $22K-$96K

Global/Freestanding – Est. to lose 3-8% (Avg. 5% loss)

- In dollars, the losses ranged between $21K-$127K

E/M Changes

Significant updates to E/M codes were finalized, which include an increase in payment, simplified coding, and documentation changes. 99201 has been deleted and 99211 has no required criteria. Complexity levels are now determined by either medical decision making or time. HPI and exam sections must still be clinically relevant to the service. The time option now provides a window of time for each level of service, plus includes a new add-on code for prolonged services. This should be added to the Level 5 codes if utilized. Note that the add-on code +99417 has a corresponding G code that CMS finalized in this rule:

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).

In addition, CMS also released add-on HCPCS +G2211, but CMS gave very little instruction for its use. HCPCS G2252 now joins G2012 for virtual check-in visits for Medicare, and these codes continue to be utilized when the 99441-99443 are discontinued after the PHE is over.

+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).*

G2252: *Brief communication technology-based service, e.g. virtual check-in by a physician or other qualified health care professional who can report evaluation and management services provided to an established patient not originating from a related E/M service provided within the previous 7 days, nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.*

G2012: *Brief communication technology-based service, e.g., virtual check-in by a physician or other qualified health care professional who can report evaluation and management services provided to an established patient not originating from a related E/M service provided within the previous 7 days, nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion.*

A summary of the coding with time follows:

Summary of Coding with Time

99201	Deleted	99211	No time definition
99202	15-29 minutes	99212	10-19 minutes
99203	30-44 minutes	99213	20-29 minutes
99204	45-59 minutes	99214	30-39 minutes
99205	60-74 minutes	99215	40-54 minutes
+99417	add to 99205, per 15 minutes over 74 min	+99417	add to 99215, per 15 min over 74 minutes

Summary of Codes and Work RVUs Finalized in the CY 2020 PFS Final Rule for CY 2021

HCPCS Code	Current Total Time (mins)	Current Work RVU	CY 2021 Total Time (mins)	CY 2021 Work RVU
99201	17	0.48	N/A	N/A
99202	22	0.93	22	0.93
99203	29	1.42	40	1.6
99204	45	2.43	60	2.6
99205	67	3.17	85	3.5
99211	7	0.18	7	0.18
99212	16	0.48	18	0.7
99213	23	0.97	30	1.3
99214	40	1.5	49	1.92
99215	55	2.11	70	2.8
G2212	N/A	N/A	15	0.61
G2211	N/A	N/A	11	0.33

Medicare Telehealth Services

Due to the public health emergency (PHE) for Coronavirus Disease 2019 (COVID-19), CMS undertook emergency rulemaking to add several services to the Medicare telehealth services list on an interim final basis. Radiation Oncology Weekly Treatment Management services was discussed in the final rule with the following outcome: Radiation Treatment Management Services (CPT codes 77427) will not be added to the telehealth list permanently or temporarily.

CPT Code 77401 (Radiation treatment delivery, superficial and/or ortho voltage, per day)

CPT 77401 was identified as a procedure code with a large volume increase of utilization. From 2012 to 2017, the utilization increased by at least 100 percent. In January 2019, the RUC recommended to refer this service to the CPT Editorial Panel to better define the set of services associated with the delivery of superficial radiation therapy (SRT). CMS proposed and finalized a direct PE change due to a reduction of two minutes for the clinical labor task, and they will not include a "lead room" as a new equipment item. They are requesting more information to determine if it is more accurately priced as direct or indirect PE.

Contractor Pricing for Protons

There was discussion regarding proton treatment delivery codes, with the CMS finalizing their proposal to maintain contractor pricing for CPT codes 77520, 77522, 77523, and 77525.

Quality Payment Programs: MIPS and MIPS APM

MIPS

2020 performance year – the deadline for applying for reweighting due to extreme and uncontrollable circumstances has been extended to February 1, 2021 at 8 PM ET. Additionally, the maximum points available for the complex patient bonus has been doubled to recognize the additional difficulty of managing patients during the PHE.

2021 performance year – the transition to the MIPS Value Pathways (MVPs) was intended to occur in the 2021 MIPS performance year. However, the timeline is changing due to the PHE, and the MVPs will now be implemented in 2022.

Quality

The weight of Quality will decrease by 5% in 2021. The Radiation Oncology Measures Set has not changed. It will continue to have the following three measures:

- 102: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients
- 143: Pain Intensity Quantified
- 144: Plan of Care for Moderate to Severe Pain.

Promoting Interoperability

The proposed new optional Health Information Exchange (HIE) bi-directional exchange measure that was proposed was finalized. Both technology on the existing 2015 Edition criteria and 2015 Edition Cures Updated criteria will be considered certified through December 31, 2022. The scoring methodology for CY 2021 is located on page 1338 of the final rule.

Performance Threshold

There was a proposal to lower the performance threshold to obtain a neutral payment adjustment to 50. This decrease was not approved, and the performance threshold will remain 60 points in 2021. It is estimated that the performance threshold will increase to 74 points in the subsequent performance year, 2022.

MIPS Performance Category Weight Changes

Performance Category	Current Performance Year	2021 Performance Year	2022 Performance Year
Quality	**45%**	**40%**	**30%**
Cost	**15%**	**20%**	**30%**
Promoting Interoperability	**25%**	**25%**	**25%**
Improvement Activities	**15%**	**15%**	**15%**

Redistribution of Performance Categories

There are scenarios where providers may be exempt or can file for exemption from a performance category. Below are some example scenarios and a chart explaining how the percentages are redistributed to other categories for performance year 2021:

- Professional physician groups that perform more than 75% of their covered services in a hospital setting are given a special status of Hospital-based, and they will automatically have the Promoting Interoperability category reweighted to zero
- Practices with 15 or fewer clinicians are given the special status of Small Practice. They can apply for hardship exemptions for the Promoting Interoperability category
- If a provider does not get attributed any patients for the Cost measures, then the percentages for this category would be redistributed.

Category redistributions for performance year 2022 are located on page 1415 of the final rule.

Performance Category Redistribution Policies Finalized for the 2021 MIPS Performance Year

Reweighting Scenario	Quality	Cost	Improvement Activities	Promoting Interoperability
No Reweighting Needed				
-Scores for all four performance categories	40%	20%	15%	25%
Reweight One Performance Category				
-No Cost	55%	0%	15%	30%
-No Promoting Interoperability	65%	20%	15%	0%
-No Quality	0%	20%	15%	65%

-No Improvement Activities	55%	20%	0%	25%
Reweight Two Performance Categories				
-No Cost and no Promoting Interoperability	85%	0%	15%	0%
-No Cost and no Quality	0%	0%	15%	85%
-No Cost and no Improvement Activities	70%	0%	0%	30%
-No Promoting Interoperability and no Quality	0%	50%	50%	0%
-No Promoting Interoperability and no Improvement Activities	80%	20%	0%	0%
-No Quality and no Improvement Activities	0%	20%	0%	80%

MIPS APMs

There were no changes to the MIPS APMs Criteria, "(1) an APM Entity participates in the APM under an agreement with CMS or through a law or regulation; and (2) the APM bases payment on quality measures and cost/utilization."

APP

The APM Performance Pathway (APP) will be implemented in 2021, allowing MIPS eligible physicians that are an APM participant to report to MIPS. This will standardize reporting, encourage APM participation, and allow reporting to be done by the individual, group, or APM entity. APP is a fixed set of measures, and these measures can be located on page 1230 in the final rule.

MIPS APM Performance Category Weights

- Quality – 50%
- Cost – 0%
- Promoting Interoperability – 30%
- Improvement Activities – 20%

Redistribution for Special Cases

In the case where Promoting Interoperability is reweighted to 0%, Quality would change to 75% and the Improvement Activities would change to 25%.

In the case where Quality is reweighted to 0%, Promoting Interoperability would change to 75% and the Improvement Activities would change to 25%.

Summation 2021 Final Rule HOPPS

Payments

CMS is increasing the payment rates under HOPPS by 2.7% overall. When looking at radiation oncology specifically, the percentage of change in payment is incremental; for example: small increases of $3.52 for simulations, increase of $16.84 for 3D and IMRT planning, increase of $51.16 for proton treatment delivery, and a decrease of $32.06 for HDR.

Reassignment of Codes

CMS finalized reassignment of two radiation oncology CPT codes which resulted in increases in reimbursement for both procedure codes to $4,271.54.

- 57155: Insertion of uterine tandem and/or vaginal ovoids for clinical brachytherapy
- 58346: Insertion of Heyman capsules for clinical brachytherapy

RO Model

In the 2021 Final Rule for HOPPS, CMS addressed via rule making the change in the start of the RO Model to July 1, 2021 due to significant stakeholder feedback requesting a delay in the implementation of the RO Model following revenue loss concerns because of the public health emergency (PHE). CMS determined in order to ensure safe delivery of efficient healthcare to beneficiaries that the implementation date must be moved. It is believed that the extra six months will give providers plenty of time to learn the RO billing requirements and train staff. With the start of the RO Model delayed six months, there were many changes addressed. A summation of the changes is below:

- Model period will last 4.5 years beginning on July 1, 2021, ending on December 31, 2025
- PY 1 = July 1, 2021 through December 31, 2021
- PY 2-5 will be the full calendar year
- Low volume opt-out for PY3 includes episodes from Jan. 1, 2021 through June 30, 2021, and RO episodes from July 1, 2021 through Dec. 31, 2021
- RO Model quality measures requirements delayed to PY2 (Jan 1, 2022 – Dec. 31, 2022)
- CAHPS Cancer Care Survey will go out beginning October 2021
- CDE's (clinical data elements) will begin on Jan. 1, 2022 with the first submission for Jan. 1, 2022- June 30, 2022 due in July 2022
- No quality withhold for PY1 due to the delay in reporting of quality measures and CDEs until PY2. Beginning PY2, the two percent quality withhold will be applied
- Quality reconciliation amounts for PY 2 – PY5 only
- RO Model will not meet criteria for an APM or MIPS APM in PY1

- CEHRT utilization required PY2-PY5. First annual certification required within 30 days of the start of PY2
- Delaying the quality reporting and CEHRT use requirements until PY2 means that the RO Model will not meet the criteria for an Advanced APM in PY1, which means RO participants are not eligible for the five percent APM Incentive Payment.

Physician Supervision

CMS has finalized a change in the minimum default level of supervision for non-surgical extended duration therapeutic services to general supervision for the entirety of the service, including the initiation portion of the service. CMS initially made this change during the PHE, giving providers the flexibility to handle the burden created by the PHE. CMS now believes that changing the level of supervision permanently would be beneficial to patients and providers. CMS does reiterate that this is a minimum, and the provider is ultimately responsible for determining when higher levels of supervision are needed, and that some procedures may need higher levels of supervision. This was in the HOPPS Rule which pertains to Hospital Outpatient Departments, this rule does not address Freestanding Centers.