AAOS
American Association of Orthopaedic Surgeons

CY 2021 Medicare Physician Fee Schedule (MPFS) Final Rule Summary
Updated January 11, 2021

On December 1, 2020 the Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS) final rule (CMS-1734-F). Below is a summary of key changes:

Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits Ask:

AAOS requested that CMS incorporate the RUC-recommended work and time incremental increases for the revised office/outpatient visit E/M codes in all the global codes, stating that it was inappropriate to apply the value increases to select global codes, disrupting the relativity mandated by Congress in 1992.

CMS Response:

- CMS finalized a policy to adopt the new coding, prefatory language, and interpretive guidance framework that has been issued by the AMA's CPT Editorial Panel regarding the revisions to office/outpatient E/M visit code set (CPT codes 99202 through 99215), which will be effective January 1, 2021.
- Under this new CPT coding framework, history and exam will no longer be used to select the level of code for office/outpatient E/M visits.
- CMS is finalizing its proposal to not extend the revisions to the E/M visit code set to the 10- and 90-day global surgical codes.

Hip-Knee Arthroplasty (CPT codes 27130 and 27447) Ask:

AAOS along with the American Association of Hip and Knee Surgeons (AAHKS) requested that CMS maintain the work RVUs (20.72) and minutes finalized in CY 2014 until patient pre-optimization activities for these procedures could be captured.

CMS Response:

- CMS is finalizing its proposal to accept the RUC-recommended work RVU of 19.60 for CPT code 27130 and the RUC-recommended work RVU of 19.60 for CPT code 27447. CMS is also finalizing the proposed RUC-recommended direct PE inputs for both codes.
- The passage of the Consolidated Appropriations Act on December 27, 2020 made updates to the CY 2021 Medicare Physician Fee Schedule, and the combined impact of the decrease in work RVUs and budget neutrality is lessened from an approximately 10% to 6.5% decrease—the new payment rates for 2021 will be $1,322.45 for THA and $1,320.70 for TKA

Toe Amputation (CPT Codes 28820 and 28825) Ask:

AAOS requested the RUC-recommended times and work RVUs of 4.10 for code 28820 and 4.00 for code 28825, providing evidence of change in patient population resulting in more complex intraoperative work due to increases in comorbidities that would affect surgery. AAOS also urged CMS to accept the RUC-recommended preoperative clinical staff time of 60 minutes for each code.

CMS Response:

- CMS is finalizing its proposal to accept the work RVUs of 3.51 for code 28820 and 3.41 for code 28825. CMS is also finalizing its proposal to refine the pre-service clinical labor times to conform to the 000-day global period standards for both codes.

Shoulder Debridement (CPT codes 29822 and 29823) Ask:
AAOS accepted CMS' proposal to accept the RUC-recommended work RVUs for codes 29822 and 29823 and did not submit comments for these codes.

CMS Response:

- CMS is finalizing its proposal to accept the RUC-recommended work RVU of 7.03 for code 29822 and 7.98 for CPT code 29823. CMS is finalizing the RUC-recommended direct PE inputs without refinement.

CY 2021 Conversion Factor Ask:
AAOS requested CMS support for the Congressional proposal to waive the statutorily mandated budget neutrality requirements in order to lessen the impact of these drastic cuts at a time when surgeons continue to shoulder greater financial risk to improve quality for less compensation.

CMS Response:

- CMS initially finalized a decrease in the 2021 conversion factor by 10.2 percent ($36.09 for 2020, down to a proposed $32.41 for 2021) citing a statutory mandate for budget neutrality resulting from changes in the work RVUs.
- However, following the passage of the Consolidated Appropriations Act on December 27, 2020, a blanket 3.75% increase was made to all payments which were originally going to be decreased by 10.2 percent.
- Additionally, the conversion factor was recalculated to mirror budget neutrality changes and is now $34.89 for 2021, up from the planned decrease to $32.41 this year from $36.09 in 2020.

Telehealth and Other Services Involving Communications Technology Ask:
CMS reiterated that telehealth rules do not apply when the beneficiary and the physician or practitioner are in the same location even if audio/video technology assists in furnishing a service. AAOS requested use of audio-only equipment for office/outpatient E/M codes 99212-99215 and 99202-99205.

CMS Response:

- CMS is establishing payment for audio-only interactions with beneficiaries on an interim final basis for a new HCPCS G-code describing 11-20 minutes of medical discussion to determine the necessity of an in-person visit.
- CMS is finalizing the expanded definition, which includes telehealth codes for virtual check-ins, e-visits, and telephonic communication, which will apply when the assignment window for a benchmark or performance year includes any months during the PHE for COVID-19.
- CMS is establishing a policy in which teaching physicians may use interactive, real-time audio/video means to interact with residents in order to meet the requirement that they be present for the key portion of the service.

- The PHE for COVID-19 has been extended into CY 2021, allowing for services added to the Medicare telehealth list on a Category 3 basis to remain for at least the entirety of 2021.

AAOS requested that CMS allow physical therapy (PT) and occupational therapy (OT) services to be performed virtually with two-way audio/visual capabilities and maintain reimbursement as if rendered in person.

CMS Response:

- CMS is finalizing that PT and OT services will remain temporarily on the Medicare telehealth list through the end of the year in which the PHE for COVID-19 ends (Category 3 services).
- PTs and OTs can furnish the brief online assessment and management services as well as virtual check-ins and remote evaluation services.
- CMS is establishing two new HCPCS G codes (HCPCS codes G2010 and G2012) in order to facilitate billing by these practitioners for the remote evaluation of patient-submitted video or images and virtual check-ins.

AAOS strongly urged CMS to accept the reimbursement rate of $6.57 for code 99072 as determined from the data received for these additional PE costs, as well as allow reporting of code 99072 retroactively to March 1, 2020, as was allowed with other reporting flexibilities during the PHE.

CMS Response:

- CMS is finalizing CPT code 99072 as a bundled service on an interim basis, as use of these additional forms of PPE would be inherent to the furnishing of separately paid services under these practitioner/patient interactions. CMS is providing a 60-day public comment period for CPT code 99072, as well as comment about other services that may not include these specific PPE items but for which there are incurred costs as described by the stakeholders. Additionally, CMS will consider the market cost for these supply items relative to the changing conditions in the market, as appropriate.

AAOS requested CMS continue to allow E-visit codes 99421-99243, and E/M telephone service codes 99441 - 99443 for both new and established patients and continue the current reimbursement for the physician's time to be equal to that of in-person services.

CMS Response:

- CMS finalized, on an interim basis for the duration of the PHE for COVID-19, while the code descriptors for e-visit codes 99241-99243 and E/M telephone service codes (99441 – 99443) refer to an "established patient", during the PHE for COVID-19, CMS is exercising enforcement discretion on an interim basis to relax enforcement of this aspect of the code descriptors.

AAOS requested Visit Complexity Inherent to Certain Office/Outpatient E/Ms, and Prolonged Services be added permanently to the Category One covered Medicare telehealth services list.

CMS response:

- CMS is finalizing for permanent addition to Medicare Telehealth Services 60 additional services including Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS G2211) and Prolonged Services (HCPCS G2212).
- However, following the passage of the Consolidated Appropriations Act on December 27, 2020, implementation of the G2211 add-on code for complex visits is suspended until 2024

AAOS requested CMS maintain all current telehealth flexibilities implemented during the COVID-19 pandemic to remain on a permanent basis after the PHE has expired.

CMS response:

- The PHE for COVID-19 has been extended into CY 2021, allowing for services added to the Medicare telehealth list on a Category 3 basis to remain for at least the entirety of 2021.
- At the conclusion of the PHE for COVID-19, these waivers and interim policies will expire and payment for Medicare telehealth services will once again be limited by the requirements of section 1834(m) of the Act, and will return to the policies established through the regular notice and comment rulemaking process, including the previously established Medicare telehealth services list.

Effect of Proposed Changes Related to Scope of Practice Ask:

AAOS asked that CMS maintain flexibilities, many of which were implemented as a result of the COVID-19 pandemic.

CMS response:

Supervision of Diagnostic Tests by Certain Nonphysician Practitioners (NPPs)

- CMS is finalizing its proposal to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs) and certified nurse-midwives (CNMs) to supervise the performance of diagnostic tests in addition to physicians.
- CMS is adding Certified Registered Nurse Anesthetists (CRNAs) to the list of non-physician practitioners who may supervise diagnostic tests, to the extent that it is applicable under state law.

Pharmacists Providing Services Incident to Physicians' Services

- Since pharmacists fall within the regulatory definition of auxiliary personnel, pharmacists may provide services incident to the services, and under the appropriate level of supervision, of the billing provider, if payment for the service is not made under the Medicare Part D benefit.

Therapy Assistants Furnishing Maintenance Therapy

- CMS is finalizing its proposal to make permanent their Part B policy for maintenance therapy services that they adopted on an interim basis for the PHE, which grants a physical therapist (PT) and occupational therapist (OT) the discretion to delegate the performance of maintenance therapy services, as clinically appropriate, to a therapy assistant – a physical therapist assistant (PTA) or an occupational therapy assistant (OTA).

Supervision of Residents

- CMS is finalizing a proposal to allow for the virtual presence of a teaching physician using audio/visual real-time communications technology for the duration of the PHE.
- CMS is finalizing the primary care exception policy to allow teaching physicians to direct care furnished by the resident and review the services furnished by the resident during or immediately after the visit remotely, using audio/visual real-time communications for the duration of the PHE.

Quality Payment Program

Flexibilities Related to the COVID-19 Pandemic: Bundled Payment for Care Improvement (BPCI) Advanced Flexibilities Ask:

AAOS asked CMS to apply uniform protections for BPCI-Advanced participants that have been provided to Comprehensive Joint Replacement (CJR) participants. For participants in the CJR program, CMS will waive repayment responsibility if episode costs increase (downside risk) and keep the ability to share in episode savings (upside risk) if episode costs are reduced.

CMS Response:

- N/A

Quality Measure Benchmark Ask:

- AAOS encouraged CMS to use benchmarks from the 2018 performance period for the 2021 performance period to provide clinicians with certainty during the COVID-19 pandemic.

CMS Response:

- CMS decided not to finalize their initial proposal to use performance period benchmarks for the CY 2021 performance period and will use historical benchmarks for CY 2021 based on the 2019 data.

Complex Patient Bonus Payment Ask:

- AAOS appreciated CMS' proposal to increase the maximum number of points available for the 2020 performance period for complex patients, in recognition of the challenges clinicians face during the COVID-19 pandemic.

CMS Response:

- CMS decided to finalize their proposal to increase the complex patient bonus for the CY 2020 performance period/2022 MIPS payment year.

Merit-based Incentive Payment System (MIPS) Performance Threshold Ask:

- AAOS appreciated the CMS proposal to reduce the performance threshold for the 2021 MIPS performance period from 60 points to 50 points.

CMS Response:

- CMS decided not to finalize their proposal to reduce the performance threshold for the 2021 MIPS performance period from 60 to 50 points, and instead finalized the performance threshold at 60 points.

Alternative Payment Models Performance Pathway (APP) Ask:

- AAOS encouraged CMS not to move forward with the APP proposal and instead re-focus their efforts on the promising MVP framework.

CMS Response:

- CMS finalized the APP as a voluntary pathway for reporting and scoring under MIPS that allows APM participants to receive an improvement activities credit and have the cost performance category reweighted.
- CMS finalized all of the proposed quality measures included in the APP quality measure set, effective January 1, 2021.
- CMS finalized the elimination of the APM scoring standard for the 2021 performance year beginning January 1, 2021.
- CMS delayed sunsetting of the CMS Web Interface by one year and is allowing APM entities to report via the CMS Web Interface measure set for the 2021 MIPS performance period.

Delay of Qualified Clinical Data Registries (QCDRs) Measure Testing & Data Collection Requirements Ask:

- AAOS expressed appreciation for the delay in the QCDR measure development requirements finalized in the CY 2020 MPFS. Though, we also strongly urged CMS to reconsider delaying implementation of QCDR measure testing to the clinician-level and pre-submission data collection until at least one year after the end of the COVID-19 public health emergency.

CMS Response:

- CMS finalized delay of QCDR measure testing and data collection requirements until January 1, 2022.

Inclusion of QCDR Measures in MIPS Value Pathways (MVPs) Ask:

- AAOS supported the optional inclusion of fully tested QCDR measures in MVPs. We also encouraged CMS to continue providing QCDR-specific education opportunities specific to MVP development and asked CMS to explore utilizing the MVP pathway as a mechanism to comply with Section 105(b) of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which directs CMS to provide QCDRs with access to Medicare data for purposes of linking such data to clinical outcomes data and performing risk-adjusted and scientifically valid and risk adjusted analyses and research to support quality improvement and patient safety.

CMS Response:

- CMS finalized optional inclusion of fully tested QCDR measures in MVPs effective January 1, 2022 (i.e. the implementation date of MVPs).

MVP Implementation Delay Ask:

- AAOS supported the proposal to delay implementation of the MIPS Value Pathways (MVPs) until CY 2022. We cautioned against letting the implementation delay slow the momentum of MVP development and encouraged CMS to continue reaching out to medical specialty associations directly to collaborate.

CMS Response:

- CMS finalized implementation of the MVP reporting option to begin with the 2022 Performance Year.

Criteria for MVP Development Ask:

- AAOS appreciated the additional detail provided by CMS on MVP development criteria and process, which was a key ask from AAOS in our comment letter from the CY 2020 MPFS Final Rule. We expressed concern for the timing of communication of MVP approval and the lack of lead time for participants to successfully implement workflows.

- To further capture the patient voice in MVPs, AAOS suggested awarding bonus points to the final composite score for inclusion of patient reported outcome measures (PROMs) in the Quality category or Improvement Activities related to collection of PROMs.

CMS Response:

- CMA finalized MVP guiding principles, development criteria, and process for candidate submissions as proposed.
- Notification of MVP approval will follow CMS' normal processes of notice and comment rulemaking.
- CMS acknowledged the importance of PRO data but did not agree to award bonus points for reporting quality measures or improvement activities related to PROMs collection.

SUPPORT Act Requirements & The Medicare Program Electronic Prescribing for Controlled Substances: Request for Information

- In general, AAOS agreed with the push requiring Electronic Prescription for Controlled Substances (EPCS) prescription transmissions for prescribers; however, we also noted the burden of purchasing and implementing EPCS software on small practices and/or practices where reliable internet connectivity is not readily available.
    - In this way, AAOS recommended application of the same criteria for the MIPS Promoting Interoperability Performance Category hardship exception for the EPCS requirements.
    - AAOS supported the delay of EPCS requirements until January 1, 2022, though we also asked CMS to consider delaying further depending upon when the PHE ends.

CMS Response:

- CMS modified their proposal and finalized a phased approach. The provision will have an effective date of January 1, 2021 and a compliance date of January 1, 2022.
- Prescribers who do not implement the NCPDP SCRIPT 2017071 standard for electronic prescribing of Schedule II, III, IV, and V controlled substances until January 1, 2022 will still be considered compliant with the requirement.
- CMS will address hardship exception criteria through future rulemaking and appreciated responses to their Request for Information.

The complete rule can be found here.