

CY 2021 Medicare Physician Fee Schedule (MPFS) Proposed Rule Summary

On August 3, 2020 the Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS) proposed rule (CMS-1734-P). AAOS will be submitting formal comments to CMS, due on October 5, 2020. Below is a summary of key proposals:

Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits (pg. 144)

-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 99201 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.
- Instead, an office/outpatient E/M visit will include a medically appropriate history and exam, when performed, and be based on either the level of MDM or the total time personally spent by the reporting practitioner on the day of the visit (including face-to-face and non-face-to-face time).
- The clinically outdated system for number of body systems/areas reviewed and examined under history and exam will no longer apply, and the history and exam components will only be performed when, and to the extent, reasonable and necessary, and clinically appropriate.
- This will further CMS' ongoing effort to reduce administrative burden, improve payment accuracy, and update the office/outpatient E/M visit code set to better reflect the current practice of medicine.
- To report prolonged time associated with office/outpatient E/M visits, CMS finalized separate payment for a new prolonged visit add-on CPT code (99XXX) and discontinued the use of CPT codes 99358 and 99359 (prolonged E/M visit without direct patient contact).
- CMS also finalized separate payment for HCPCS code (GPC1X), to provide payment for visit complexity inherent to E/M 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, or complex chronic condition.
- CMS is not extending the revisions to the E/M visit code set to the 10- and 90-day global surgical codes.

Time Values for Levels 2-5 Office/Outpatient E/M Visit Codes

-In the CY 2020 PFS proposed rule, CMS sought comment on the times associated with the office/outpatient E/M visits as recommended by the AMA RUC. When surveying these services for purposes of valuation, the AMA RUC requested that survey respondents consider the total time spent on the day of the visit, as well as any pre- and post-service time occurring within a timeframe of 3 days prior to the visit and 7 days after, respectively. The AMA RUC then separately averaged the survey results for pre-service,

day of service, and post-service times, and the survey results for total time, with the result that, for some of the codes, the sum of the times associated with the three service periods does not match the RUC-recommended total time. The approach used by the AMA RUC to develop recommendations sometimes resulted in two conflicting sets of times: the component times as surveyed and the total time as surveyed. -In the CY 2020 PFS final rule, CMS finalized adoption of the RUC-recommended times, but stated that it would continue to consider whether this issue has implications for the PFS broadly. When CMS establish pre-, intra-, and post-service times for a service under the PFS, these times always sum to the total time. Commenters on the CY 2020 PFS proposed rule (84 FR 62849) stated that CMS should adopt the times as recommended by the RUC, but did not provide any additional details on the times they believed should be used when the total time is not the sum of the component times.

-Given the lack of clarity provided by commenters on the CY 2020 PFS proposed rule about why the sum of minutes in the components would differ from the total minutes, and the CMS view and systems requirement that total time must equal the mathematical total of component times, CMS is proposing beginning for CY 2021 to adopt the actual total times (defined as the sum of the component times) rather than the total times recommended by the AMA RUC for CPT codes 99202 through 99215.

- **CPT code 99202**, current total time 22 minutes - **CY 2021 Total time: 20 minutes**
- **CPT code 99203**, current total time 29 minutes - **CY 2021 Total time: 35 minutes**
- **CPT code 99204**, current total time 45 minutes - **CY 2021 Total time: 60 minutes**
- **CPT code 99205**, current total time 67 minutes - **CY 2021 Total time: 88 minutes**
- **CPT code 99211**, current total time 7 minutes - **CY 2021 Total time: 7 minutes**
- **CPT code 99212**, current total time 16 minutes - **CY 2021 Total time: 16 minutes**
- **CPT code 99213**, current total time 23 minutes - **CY 2021 Total time: 30 minutes**
- **CPT code 99214**, current total time 40 minutes - **CY 2021 Total time: 47 minutes**
- **CPT code 99215**, current total time 55 minutes - **CY 2021 Total time: 70 minutes**

Hip-Knee Arthroplasty (CPT codes 27130 and 27447)

-In the CY 2019 final rule (83 FR 59500 through 595303), CPT codes 27130 (*Arthroplasty, acetabular and proximal femoral prosthetic replacement (total hip arthroplasty), with or without autograft or allograft*) and 27447 (*Arthroplasty, knee, condyle and plateau; medial AND lateral compartments with or without patella resurfacing (total knee arthroplasty)*) were added to the list of potentially misvalued codes via a stakeholder nomination.

-The stakeholder stated that there were substantial overestimates in pre-service and post-service time including follow-up inpatient and outpatient visits that do not take place included in the valuation of the service. The codes were resurveyed for the October 2019 RUC meeting.

-CMS is proposing 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 proposing the RUC-recommended direct PE inputs for both codes.

-CMS is proposing 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 proposing the RUC-recommended direct PE inputs for both codes.

- CMS is asking for comment on how to include pre-optimization time (pre-service work/activities ancillary to surgical outcome improvement) in the future.
- CMS is requesting stakeholder feedback on what codes could be used to capture the pre-optimization activities.

Proposed Valuation of Specific Codes

Toe Amputation (CPT codes 28820 and 28825)

-CPT Code 28820 (*Amputation, toe; metatarsophalangeal joint*) and 28825 (*Amputation, toe; interphalangeal joint*) were identified by the RUC Relativity assessment Workgroup through a site of service anomaly for services with a utilization over 10,000 in which a service is typically performed in the inpatient hospital setting, yet only a half day discharge day management identified by CPT code 99238 is included.

-CMS is proposing these codes as 000-day global codes. CMS disagrees with the RUC-recommended work RVU of 4.10 for CPT code 28820 and is proposing a work RVU of 3.51. CMS disagrees with the RUC recommended work RVU of 4.00 for CPT code 28825 and is proposing a work RVU of 3.41.

-For direct PE inputs, CMS is proposing to refine the pre-service clinical labor times to conform to the 000-day global period standard for both codes in the family. They are proposing to refine the clinical labor times for the “Provide education/obtain consent” (CA011) and the “Prepare room, equipment and supplies” (CA013) activities to conform to their established standard time of 2 minutes each in the non-facility setting.

-CMS is also proposing to refine the equipment time to conform to these changes in the clinical labor time for both codes.

Shoulder Debridement (CPT codes 29822 and 29823)

-CMS is proposing the RUC-recommended work RVU of 7.03 for CPT code 29822 and 7.98 for CPT code 29823 without refinement.

-For the direct PE inputs, CMS is proposing the RUC recommendations CPT codes 29822 and 29823 without refinement.

Finalized Valuation of Specific Codes

-**Current wRVU 0.93 remains** for CPT code **99202**, *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, total time is spent on the date of the encounter.*

-**Increased wRVU from 1.42 to 1.6** for CPT code **99203**, *Office or other outpatient visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.*

-**Increased wRVU from 2.43 to 2.6** for CPT code **99204**, *Office or other outpatient visit for the evaluation and management of a new patient, which requires medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.*

- Increased wRVU from 3.17 to 3.5** for CPT code **99205**, *Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.*
- Current wRVU 0.18 remains** for CPT code **99211**, *Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.*
- Increased wRVU from 0.48 to 0.7** for CPT code **99212**, *Office or other outpatient visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.*
- Increased wRVU from 0.97 to 1.3** for CPT code **99213**, *Office or other outpatient visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.*
- Increased wRVU from 1.5 to 1.92** for CPT code **99214**, *Office or other outpatient visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.*
- Increased wRVU from 2.11 to 2.8** for CPT code **99215**, *Office or other outpatient visit for the evaluation and management of an established patient, which requires medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.*
- wRVU 0.61** for Prolonged Services CPT code **99XXX**
- wRVU 0.33** for HCPCS code **GPCIX**

Potentially Misvalued Services Under the PFS

- CMS received multiple submissions requesting that they consider CPT code 22867 (*Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level*) for nomination as potentially misvalued as the physician work assigned to this code significantly undervalues the procedure relative to the value of CPT code 63047 (*Laminectomy, facetectomy and foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s], [eg, spinal or lateral recess stenosis]), single vertebral segment; lumbar*).
- The submitters also stated that the work performed during the surgical steps to perform a laminectomy for both procedures is generally similar except for the additional intensity and complexity involved in CPT code 22867 to implant the interspinous stabilization device.
- The submitters also requested that the malpractice RVUs assigned to this code be increased to better align with similar spine procedures, in terms of specialty level and service level risk factors, in addition to the intensity and complexity of the procedure.

CY 2021 Conversion Factor

-CMS is proposing to decrease the 2021 conversion factor by 11 percent (\$36.089 for 2020 down to a proposed \$32.2605 for 2021) citing a statutory mandate for budget neutrality resulting from changes in the work RVUs

Telehealth and Other Services Involving Communications Technology

-CMS is proposing to make permanent additions to the Category 1 Medicare telehealth services list: Group Psychotherapy (90853), Domiciliary, Rest Home, or Custodial Care services, Established patients (99334-99335), Home Visits, Established Patient (99347-99348), Cognitive Assessment and Care Planning Services (99483), Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS code GPC1X), Prolonged Services (99XXX), and Psychological and Neuropsychological Testing (96121).

- These services are being considered for addition to the Medicare telehealth services list permanently or on an interim basis after the end of the PHE.

-CMS is proposing temporary Category 3 additions to the Medicare telehealth services list: Domiciliary, Rest Home, or Custodial Care services, Established patients (99336-99337), Home Visits, Established Patient (99349-99350), Emergency Department Visits Levels 1-3 (99281-99283), Nursing Facilities Discharge Day Management (99315-99316), and Psychological and Neuropsychological Testing (96130-96133).

- Any service added under the proposed Category III would remain on the Medicare telehealth services list through the calendar year in which the PHE ends.

-CMS is reiterating that telehealth rules do not apply when the beneficiary and the individual physician or practitioner are in the same location even if audio/video technology assists in furnishing a service.

- In the March 31st, 2020 COVID-19 IFC, CMS established separate payment for audio-only telephone evaluation and management services. CMS is not proposing to continue to recognize these codes for payment under the PFS in the absence of the PHE for the COVID-19 pandemic, however the need for audio-only interactions could remain as beneficiaries continue to try to avoid sources of potential infection. CMS is proposing to develop coding and payment for a service similar to the virtual check-in, but for a longer unit of time and with a higher value, and on if this should be a provisional policy to remain in effect until a year after the end of the PHE for the COVID-19 pandemic or if it should be PFS payment policy permanently.

Effect of Proposed Changes Related to Scope of Practice

-Supervision of Diagnostic tests by Certain Nonphysician Practitioners (NPPs)

- This proposal would 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 proposing to make permanent following the COVID-19 PHE, the same policy that was finalized under the May 1st COVID-19 IFC, for the duration of the COVID-19 PHE.
- If finalized on a permanent basis effective January 1, 2021, NPs, CNSs, PAs and CNMs would be allowed under the Medicare Part B program to supervise the performance of diagnostic tests within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians.

-Pharmacists Providing Services Incident to Physicians' Services

- Pharmacists may provide services incident to the services, and under the appropriate level of supervision, of the billing physician or NPP, if payment for the service is not made under the Medicare Part D benefit.
- CMS is reiterating the clarification they provided in the May 1st COVID-19 IFC (85 FR 27550 through 27629), that pharmacists fall within the regulatory definition of auxiliary personnel under our "incident to" regulations.
- This proposal includes providing the services incident to the services of the billing physician or NPP and in accordance with the pharmacist's state scope of practice and applicable state law.

-Therapy Assistants Furnishing Maintenance Therapy

- CMS is proposing to make permanent their Part B policy for maintenance therapy services that they adopted on an interim basis for the PHE in the May 1st COVID-19 IFC that 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).
- CMS no longer believes all such maintenance therapy services require the PT or OT to personally perform them and to better align their Part B policy with that paid under Part A in skilled nursing facilities and the home health benefit where maintenance therapy services may be performed by a PT/OT or a PTA/OTA.
- The proposed policy would allow PTs/OTs to use the same discretion to delegate maintenance therapy services to PTAs/OTAs that they utilize for rehabilitative services.
- CMS also proposes to revise their sub regulatory provisions to clarify that PTs and OTs no longer need to personally perform maintenance therapy services and to remove the prohibitions on PTAs and OTAs from furnishing such services.
- Should the PHE end before January 1, 2021, the PT or OT would need to personally furnish the maintenance therapy services until the proposed policy change takes effect.

Medical Record Documentation

-In the CY 2020 PFS final rule, CMS finalized broad modifications to the medical record documentation requirements for the physician and certain NPPs in the CY 2020 PFS final rule.

-In the CY 2021 PFS proposed rule, CMS is clarifying that physicians and NPPs, including therapists can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the PFS.

-CMS is also clarifying that therapy students, and students of other disciplines, working under a physician or practitioner who furnishes and bills directly for their professional services to the Medicare program, may document in the record so long as it is reviewed and verified (signed and dated) by the billing physician, practitioner, or therapist.

Payment for Services of Teaching Physicians

CMS is considering whether the following policies should be extended on a temporary basis or to be made permanent once the PHE ends:

- CMS proposed that the teaching physicians may use audio/video real time communications technology to interact with the resident through virtual means, which would meet the requirement that they be present for the key portion of the service, including when the teaching physician involves the resident in furnishing Medicare Telehealth services.
- Teaching physicians involving residents in providing care at primary care centers can provide the necessary direction, management and review for the resident's services using audio/video real time communications technology.
- Residents furnishing services at primary care centers may furnish an expanded set of services to beneficiaries, including levels 4-5 of an office/outpatient evaluation and management (E/M) visit, care management, and communication technology-based services.
- During the COVID-19 PHE, Medicare also considers the services of residents that are furnished outside of the scope of their approved GME programs and furnished to inpatients of a hospital in which they have their training program as separately billable physicians' services.

Alternative Payment Models

-CMS is introducing the APM Performance Pathway (APP) for the 2021 performance year, which is "designed to provide a predictable and consistent Merit-based Incentive Payment System (MIPS) reporting standard to reduce reporting burden and encourage continued APM participation."

- The APP would be for MIPS APMs participants only and would be required for Medicare Shared Savings Program (MSSP) quality performance reporting.
- Much like the MIPS Value Pathway (MVPs), the APP would be comprised of a fixed set of measures for each performance category.
- The Cost performance category would be weighted at 0%.
- The Improvement Activity (IA) performance category score would automatically be assigned based on the IA requirements of the MIPS APM in which the MIPS eligible clinician participates.
 - All APM participants reporting the APP would earn a score of 100% on the IA category for the 2021 performance period.
- Promoting Interoperability performance category reporting and scoring would be the same as the rest of the MIPS program.
- The Quality performance category would be comprised of the following 6 measures:
 - CAHPS for MIPS (QID #321)
 - Diabetes: Hemoglobin A1c (HbA1c) Poor Control (QID #001)
 - Preventive Care and Screening: Screening for Depression and Follow-up Plan (QID #134)
 - Controlling High Blood Pressure (QID #236)
 - Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups (Measure ID# TBD)
 - Risk Standardized, All-Cause Unplanned Admissions for Multiple Chronic Conditions for ACOs (Measure ID# TBD)
- CMS proposes to reweight the performance categories for APM participants reporting through the APP to:

- Quality: 50%
- Cost: 0%
- Promoting Interoperability: 30%
- Improvement Activities: 20%
- The final scoring for APM participants reporting to MIPS through the APP would follow the same methodology as established for MIPS.

Registry Data & Third-Party Intermediaries

-For the 2021 performance period, QCDRs, Qualified Registries, and Health IT Vendors may support data submission for the APM Performance Pathway (APP).

-For the 2022 performance period, QCDRs, Qualified Registries, and Health IT vendors may support data submission for MVPs.

-CMS is proposing specific obligations for QCDRs and qualified registries when conducting annual data validation audits.

- If errors are found, CMS proposes targeted audits (compared to “detailed audits” in the CY 2020 MPFS Final Rule).

-CMS is seeking comment on whether similar data validation should be required of Health IT Vendors and CAHPS vendors.

-CMS is proposing two additional approval criteria for Third Party Intermediary participation in MIPS:

- “The entity’s compliance with the requirements of this section for any prior MIPS performance period for which it was approved as a third-party intermediary.”
- “Whether the entity provided inaccurate information to the clinicians regarding Quality Payment Program requirements.”

-As a part of the corrective action plan (CAP) for Third Party Intermediary remedial action, CMS proposes policies that would requires them to provide detail on the issues contributing to noncompliance and the impact to individual clinicians, groups, or virtual groups.

-CMS proposes delaying the QCDR measure testing requirement adopted in the CY 2020 MPFS Final Rule until 2022.

- The measure testing process will be two-step, graduating from face validity to full measure testing (beta testing).
- Measures approved for CY 2020 would have to show face validity at the time of self-nomination for CY 2022. Once approved with face validity, a measure must be fully tested (i.e. beta-tested per the CMS Measures Blueprint definition) prior to self-nomination for any subsequent performance period.

-CMS is also proposing delaying the QCDR measure data collection requirement adopted in the CY 2020 MPFS Final Rule until 2022.

MIPS Value Pathways (MVPs)

-CMS is not proposing any candidate MVPs in this proposed rule.

-MVPs will not be available as a MIPS reporting option until the 2022 performance period (or later).

-No major changes to MVP guiding principles. Changes are indicated in *italics* below:

- MVPs should consist of limited, connected, complementary sets of measures and activities that are meaningful to clinicians, which will reduce clinician burden, align scoring, and lead to sufficient comparative data.
- MVPs should include measures and activities that would result in providing comparative performance data that is valuable to patients and caregivers in evaluating clinician performance and making choices about their care; MVPs will enhance this comparative performance data as they allow subgroup reporting that comprehensively reflects the services provided by multispecialty groups.
- MVPs should include measures selected using the Meaningful Measures approach and, wherever possible, the patient voice must be included, to encourage performance improvements in high priority areas.
- MVPs should reduce barriers to APM participation by including measures that are part of APMs where feasible, and by linking cost and quality measurement. (No change)
- MVPs should support the transition to digital quality measures.

-CMS proposes new MVP development criteria after receiving feedback from stakeholders, including AAOS, on the CY 2020 MPFS Final Rule urging them to provide more guidance. These new criteria are as follows:

- Utilize measures and activities across all four performance categories, if feasible
- Have a clearly defined intent of measurement
- Align with the Meaningful Measure Framework
- Have measure and activity linkages within the MVP
- Be clinically appropriate
- Be developed collaboratively across specialties in instances where the MVP is relevant to multiple specialties
- Be comprehensive and understandable by clinicians, groups, and patients
- To the extent feasible, include electronically specified quality measures
- Incorporates the patient voice
- Ensures quality measures align with existing MIPS quality measure criteria, and considers the following:
 - Whether the quality measures are applicable and available to the clinicians and groups.
- **Beginning with the 2022 performance period, may include QCDR measures that have been fully tested**
- Ensures that the cost measure is related to the other measures and activities included in the MVP, and if a relevant cost measure for specific types of care are not available, includes a broadly applicable cost measure that is applicable to the clinician type, and considers what additional cost measures should be prioritized for future development and inclusion in the MVP
- Includes improvement activities that can improve the quality of performance in clinical practice, that complement and/or supplement the quality action of the measures in the MVP, and uses broadly applicable improvement activities when specialty or sub-specialty improvement activities are not available
- Must include the entire set of Promoting Interoperability measures

- Includes the administrative-claims based measure, Hospital-Wide, 30-day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment System Program (MIPS) Eligible Clinician Groups
- CMS also proposes a process for candidate MVP collaboration, solicitation, and evaluation.
 - CMS will hold a public facing MVP development webinar to review MVP development criteria, timelines, and process in which to submit a candidate MVP.
 - **Stakeholders would formally submit their MVP candidates using a standardized template (to be published in the QPP Resource Library).**
 - CMS would review and evaluate MVP candidates as they are received (asking follow-up questions as needed), against the criteria described above.
 - CMS would also vet the quality, QCDR, and cost measures from a technical perspective to validate the coding and inclusion of clinician types intended to be measured.
 - When an MVP candidate is identified as feasible for the upcoming performance periods, CMS would schedule meetings with the stakeholder collaborators to discuss their feedback and next steps.
 - Because MVPs must be established through rulemaking, CMS will not communicate to the stakeholder whether an MVP candidate has been approved, disapproved, or is being considered for a future year, prior to the publication of the proposed rule.

MIPS Performance Category Weighting

-Per statutory requirements, CMS is proposing MIPS category weighting that shifts more to the Cost category:

- Quality: 40% (Down 5% from performance year 2020)
- Promoting Interoperability: 25% (no change)
- Improvement Activities: 15% (no change)
- Cost: 20% (Up 5% from performance year 2020)

-CMS is proposing to sunset the CMS Web Interface measures as a collection type/submission type starting with the 2021 performance period.

-CMS intends to use CY 2021 data to calculate CY 2021 quality measure benchmarks rather than historical data from CY 2019 due to the COVID-19 pandemic.

-For the 2021 performance period and beyond, CMS proposes capping measures that are identified as topped out for 2 or more consecutive years at 7 achievement points.

Quality Performance Category

-CMS is proposing two new administrative claims quality measures:

- Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the MIPS Eligible Clinician Groups
- **Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for Merit-based Incentive Payment System (MIPS) Eligible Clinician**, which applies to individual clinicians, groups and virtual groups that meet the case minimum (25 cases).
 - This measure is a revised version of NQF #1550.

Cost Performance Category

-For the 2021 performance period and future performance periods, CMS proposes to add costs associated with telehealth services to previously established cost measures.

Improvement Activities Performance Category

-CMS is proposing that new MIPS improvement activities submitted should be linked to existing and related quality and cost measures, beginning with the 2021 Call for Activities.

-CMS proposes to consider HHS-nominated improvement activities all year long.

Promoting Interoperability

-Starting with the 2024 MIPS payment year and each subsequent year, CMS will require a minimum continuous 90-day period for the Promoting Interoperability performance category calendar year.

-For the performance period in CY 2021, CMS is going to increase the bonus points for the “Query of PDMP” measure from 5 points to 10 points.

-For the performance period in CY 2021, CMS will include a new measure called “Health Information Exchange (HIE) Bi-Directional Exchange”. It will be an optional alternative to the two existing measures: “Support Electronic Referral Loops by Sending Health Information” and “Support Electronic Referral Loops by Receiving and Incorporating Health Information”.

-Establish a performance period for the Promoting Interoperability performance category of a minimum of a continuous 90-day period within the calendar year that occurs 2 years prior to the applicable MIPS payment year, up to and including the full calendar year.

Electronic Prescribing for Controlled Substances

-CMS is overriding the January 1, 2021 statutory mandate to have electronic prescribing of controlled substances (EPCS) and extending it to January 1, 2022 to account for the COVID-19 pandemic.

-CMS proposes to require that technology used to meet certified electronic health record technology (CEHRT) be updated to the finalized criteria in the 21st Century Cures Act final (interoperability and information blocking) rule.

Opioid Use Disorder Treatment Services

-CMS is proposing to create new add-on codes for nasal naloxone and for auto-injector naloxone

- Proposed price for nasal naloxone would be \$89.63 per 2-pack
- Proposed price for auto-injector naloxone would be \$178 per 2-pack

The complete rule can be found online [here](#).

The AAOS high-level summary of this proposed rule can be found online [here](#).