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The 2021 Medicare Payment and CPT Coding Update

This year's changes bode well for family physicians, with an expected increase in Medicare allowed charges.

Last year was one of the most challenging family medicine has ever experienced. But the start of 2021 ushered in changes to Medicare documentation and payment policy that should provide some financial help and some documentation relief. This article includes a summary of those reforms, as well as changes to CPT coding and Medicare's Quality Payment Program (QPP) that are relevant to family physicians.

MEDICARE PHYSICIAN FEE SCHEDULE CHANGES

The most impactful change in the 2021 Medicare Physician Fee Schedule is the revaluation of the office/outpatient evaluation and management (E/M) codes, 99202-99215. Between that and other changes, the Centers for Medicare & Medicaid Services (CMS) initially estimated that family physicians would receive an increase of 13% in Medicare allowed charges, but following last minute Congressional action to address the budget neutrality requirement, the overall increase will likely be slightly lower. Official CMS projections are pending, and this article will be updated when they are available.

In addition to increasing E/M office visit values, CMS revalued multiple code sets related to office/outpatient E/M visits. They include codes for the following services:

- Transitional care management services,
- Maternity services,
- Cognitive impairment assessment and care planning,
- Initial preventive physical examinations ("Welcome to Medicare" visits) and annual wellness visits,
- Emergency Department visits.

Remote patient monitoring. CMS is also making several changes that should make it easier to bill Medicare for remote patient monitoring (RPM) of physiologic parameters:

- Permanently allowing consent to be obtained at the time RPM services are furnished,
- Allowing auxiliary personnel to furnish RPM services (as described by CPT codes 99453 and 99454) under the billing physician's supervision,

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• Clarifying that RPM services can be furnished to patients with acute conditions as well as those with chronic conditions,

• Clarifying that interactive communication (for the purposes of CPT codes 99457 and 99458) involves real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other data transmission.

When the COVID-19 public health emergency (PHE) ends, CMS will again require that an established patient-physician relationship exist before furnishing RPM services and that at least 16 days of data be collected and transmitted each 30 days to bill codes 99453 and 99454. But as long as the PHE persists, CMS will continue allowing RPM services for new patients and allowing reporting of codes 99453 and 99454 even when fewer than 16 days of data have been collected.

Virtual check-ins. In another move that should be helpful during the pandemic, CMS has created an interim virtual check-in code for 2021 that can be used to bill for somewhat longer audio-only services. The code, G2252, can be billed for a virtual check-in that includes 11-20 minutes of medical discussion if the check-in does not originate from a related E/M service in the previous seven days or lead to a related E/M service or procedure within 24 hours or the time until the soonest available appointment.

KEY POINTS

- The Centers for Medicare & Medicaid Services has increased the values of outpatient evaluation and management (E/M) codes, as well as some other code sets related to outpatient E/M services.
- Changes to the Medicare Quality Payment Program for 2021 include a reweighting of some performance categories and an increase in the performance points threshold.
- There are hundreds of changes related to CPT codes this year, including revised descriptors for prolonged services and chronic care management codes.

Those changes should all be helpful for family physicians. However, there was some bad news in the Medicare updates.

Immunizations. CMS opted to not establish new payment rates for administering immunizations, leaving the rates at 2019 levels. This is unfortunate, given the likelihood of widespread COVID-19 vaccinations this year.

Prolonged services. Equally unfortunate, CMS has decided it will not allow physicians and other qualified health professions to bill for prolonged services unless they exceed the *maximum* total time of a level 5 E/M visit by at least 15 minutes. The CPT Editorial Panel's guidance was that prolonged services could be billed after a visit exceeds the *minimum* level 5 threshold by 15 minutes. Because Medicare's definition differs from CPT's, CMS created a new HCPCS code, G2212, for prolonged services to be used instead of the CPT code, 99417.

Primary care add-on code. A new Medicare add-on code for visit complexity, G2211, was set to increase pay for primary care physicians even more, but just before the new year, Congress voted to delay implementation of the code for three years. CMS recalculated the Medicare physician fee schedule conversion factor to reflect these changes and the revised figure for 2021 is $34.8931. Payment for most office-based E/M services still increased as planned on Jan. 1, 2021. The revised payment rates and other information are available in the "Downloads" section of the 2021 Physician Fee Schedule final rule (CMS-1734-F) webpage.

QUALITY PAYMENT PROGRAM CHANGES

CMS is making the following changes to the Merit-based Incentive Payment System (MIPS) portion of the QPP:

• Increasing the performance threshold to 60 points and keeping the exceptional performer threshold at 85 points. Eligible clinicians will receive a payment increase of up to 9% or decrease of up to 9% on their Medicare Part B claims in 2023 depending on how their performance compares to the threshold.

• Reducing the quality performance category to 40% of the final score and increasing the cost performance category to 20% of the final score. The improvement activities and promoting interoperability performance category weights will remain unchanged at 15% and 25%, respectively. The quality and cost categories will be equally weighted at 30% beginning with

the 2022 performance year.

- Postponing implementation of MIPS Value Pathways (MVPs) until 2022 and refining the MVP guiding principles.
- Sunsetting the web interface as a MIPS reporting mechanism. Starting with the 2022 performance year, those who use the interface will instead have to start using one of the other existing reporting mechanisms (EHR, qualified registry, or qualified clinical data registry).
- Updating the cost measure specifications to include telehealth services that are directly applicable to episode-based cost measures and the total per capita cost measure.
- Permanently establishing a continuous 90-day performance period for the promoting interoperability performance category. CMS will maintain the Query of Prescription Drug Monitoring Program as an optional measure worth up to 10 bonus points and add an optional bi-directional Health Information Exchange measure.
- Using the 2019 performance year to calculate benchmarks for the quality performance category and creating two new administrative claims measures: 1) Hospital-wide 30-day all-cause unplanned readmissions for groups of 16 or more clinicians with a case minimum of 200 and 2) Risk-standardized complication rate following elective primary total hip arthroplasty and/or total knee arthroplasty for eligible clinicians, groups, and virtual groups with a 25-case minimum (measured over a three-year period).

The Extreme and Uncontrollable Circumstances Exception (https://qpp.cms.gov/mips/exception-applications#extremeCircumstancesException-2020) allows MIPS participants to request reweighting for any of the performance categories. CMS automatically applied the exception to performance year 2019 because of the COVID-19 pandemic, but is not doing so for performance year 2020. Instead, eligible clinicians must apply for it. The deadline is Feb. 1. Eligible clinicians will also be able to apply for the exception for the 2021 performance year because of the pandemic. Groups, virtual groups, accountable care organizations (ACOs), and alternative payment model (APM) entities are also eligible to apply for an exception for one or more performance categories.

There's more on APMs: CMS is ending the APM Scoring Standard and implementing the APM Performance Pathway instead. The APM Performance Pathway may be reported by individual eligible clinicians, group tax identification numbers, and APM entities. The APM Performance Pathway will include a fixed set of quality measures.

For Advanced Alternative Payment Model participants, CMS is making technical changes to the qualified participant (QP) threshold score calculation. CMS is also implementing a targeted QP and partial QP review option for eligible clinicians who believe they were erroneously excluded from an APM Entity's Participation List.

CMS is waiving the Consumer Assessment of Healthcare Providers and Systems reporting requirement for 2020 for ACOs.

Lastly, CMS is waiving the Consumer Assessment of Healthcare Providers and Systems reporting requirement for 2020 for ACOs and automatically giving all of them full credit for the assessment.

CPT CHANGES

The 2021 CPT code set includes 329 changes from last year's edition, including 206 new codes, 69 revisions, and 54 deletions. The changes to the office/outpatient visit E/M services are the most significant for family medicine, and FPM has covered them thoroughly in other articles (see "Countdown to the E/M Coding Changes," https://www.aafp.org/fpm/2020/0900/p29.html, and "The 2021 Office Visit Coding Changes: Putting the Pieces Together," https://www.aafp.org/fpm/2020/1100/p6.html). Here's the best of the rest from a family medicine perspective.

Prolonged services codes. CPT has revised some of its prolonged services codes, changing the descriptors of 99354 and 99355 to clarify that they may not be used with the office E/M codes 99202-99215.

The revisions also clarify that those two codes are for outpatient care that requires direct patient contact "beyond the time of the usual service." The prior language was "beyond the typical service time of the primary procedure."

Similarly, CPT has clarified the amount of time required to report prolonged clinical staff services with codes 99415 and 99416. The revised descriptors specify that you report these codes when services exceed the "highest time in the range of total time of the service," rather than the "typical time."

Five immunizations that have appeared in CPT before will now be listed as Food and Drug Administration-approved vaccines.

CPT has also revised the descriptor of prolonged services code 99356 to clarify that you may report it separately in addition to a code for an inpatient "or observation" E/M service.

Chronic care management services. CPT has made changes to the chronic care management (CCM) codes, too. Previously, there was no upper time limit for CCM code 99490 (it included "at least" 20 minutes of clinical staff time). For 2021, CPT has revised the code descriptor to limit it to the "first 20 minutes" of clinical staff time. Time beyond that should be reported with new add-on code 99439, which covers "each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month." Code 99439 is limited to two units.

Complex CCM services described by codes 99487 and 99489 used to require "establishment or substantial revision of a comprehensive care plan." But that language has now changed to "comprehensive care plan established, implemented, revised, or monitored."

Vaccines. Five immunizations that have appeared in CPT before will now be listed as Food and Drug Administration-approved vaccines:

- 90587: Dengue vaccine, quadrivalent, live, 3 dose schedule, for subcutaneous use,
- 90619: Meningococcal conjugate vaccine, serogroups A, C, W, Y, quadrivalent, tetanus toxoid carrier (MenACWY-TT), for intramuscular use,
- 90689: Influenza virus vaccine, quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25 mL dosage, for intramuscular use,
- 90694 Influenza virus vaccine, quadrivalent (aIIV4), inactivated, adjuvanted, preservative free, 0.5 mL dosage, for intramuscular use,
- 90697: Diphtheria, tetanus toxoids, acellular pertussis vaccine, inactivated poliovirus vaccine, Haemophilus influenzae type b PRP-OMP conjugate vaccine, and hepatitis B vaccine (DTaP-IPV-Hib-HepB), for intramuscular use

Retinal imaging. Family physicians who have patients with diabetes may be using remote retinal imaging to detect and manage diabetic retinopathy. CPT has revised the two existing codes (92227 and 92228) for this service. First, the revised descriptors will reflect that either code may be used for detection "or monitoring" of disease. Code 92227 now involves "remote clinical staff review and report," while 92228 involves "remote physician or other qualified health care professional interpretation and report."

Additionally, CPT has added a new code, 92229, which describes "Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral." Code 92229 may not be reported in conjunction with 92227 or 92228.

These are not all the updates to the Medicare physician fee schedule, QPP, or CPT codes. But this is a high-level list of the most important changes you need to know about as 2021 begins. As always, how individual payers approach these changes may vary, so you're advised to consult with those in your area to find out how they will handle them. FPM

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