CMS Issues Final 2021 Medicare Fee Schedule Rule: 3 Big Takeaways

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On Tuesday, Dec. 1, the Centers for Medicare & Medicaid Services (CMS) released a 2,165-page Final Rule related to the Medicare Physician Fee Schedule, the Quality Payment Program, the Medicare Shared Savings Program, and more. While the FMA and other organizations continue to analyze the rule and work on thoroughly summarizing its provisions, there are at least three important broad aspects of the rule that all physicians should be aware of.

1. **Because of flawed 'budget neutrality' requirements, Congress must act to prevent cuts threatening access to care**

First, CMS finalized its proposal to dramatically increase the value of office and outpatient evaluation and management (EM) services and to create an additional add-on code (G2211) for certain complex EM visits. These changes will provide a much-deserved pay increase for primary care physicians and other specialists who routinely bill for these historically undervalued services.

However, by law, increases to payments for some services must be offset by cuts to others. This is known as budget neutrality. And because the increase in the valuation of EM codes is so substantial, the pay cut for other services will be as much as 10 percent. This means that physicians including anesthesiologists, emergency physicians, pathologists, radiologists, surgical specialists, and many other procedural specialists will see a significant net decrease in their Medicare reimbursements. (An estimated breakdown of the effects on each specialty is available in the table at the end of this document.) Of course, this is beyond unacceptable. While it would never be appropriate to reduce already-marginal Medicare reimbursements that haven't kept pace with inflation in years, it is especially egregious to institute these substantial cuts at a time when the economic viability of physician practices is already threatened as a result of a global pandemic. For months, the FMA has been advocating for Congress to address this looming crisis by waiving budget neutrality through legislation that would allow for increased valuation of EM codes without cutting pay for other services.

It would be outrageous for Congress to allow misguided budget neutrality requirements to threaten vital access to care during a pandemic after years of failing to provide for Medicare pay increases that keep pace with inflation. The FMA and other physician organizations across the nation are doing everything possible in urging Congress to waive these misguided budget neutrality requirements. In addition, the FMA continues to strongly advocate for policy that would make future Medicare payments more sustainable, such as instituting automatic annual pay increases that keep pace with inflation.

2. **EM coding changes are on the horizon.**

In addition to moving forward with changes to EM coding valuations, CMS has also finalized its proposal to substantially overhaul the way physicians code for EM services, effective Jan. 1, 2021. These changes have the potential to reduce some of the administrative burden and complexity associated with billing for these services. A summary of some of these provisions follows:

- CMS proposes to retain all 5 levels of coding for established patients, while reducing the number of coding levels to 4 for new patients;
- CMS will implement a new code for extended office visit time;
- Physicians will be able to justify EM coding levels using either medical decision making (MDM) or total time;
- CMS will eliminate the history and physical exam as elements for code selection, though physicians should still perform these service elements as medically appropriate.

To say the least, these upcoming changes are substantial, and physicians and office staff should educate themselves as soon as possible. Fortunately, the AMA has put together a series of comprehensives articles and resources on these upcoming changes that can be accessed for free.

In addition, rest assured that that the FMA will continue advocating on behalf of our members and sharing timely information in future issues of FMA News.

3. **CMS expands telehealth services but Congress must make increased telehealth access permanent.**

The rule moves to permanently reimburse for multiple codes that were temporarily added during the COVID-19 PHE, including prolonged office or outpatient EM codes. While CMS did not authorize payment for audio-only telehealth services beyond the duration of the PHE in its Final Rule, the administration did establish payment 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.

While some news articles have suggested that CMS' proposal amounts to a permanent extension of the telehealth flexibilities that have been made available during the pandemic, this is unfortunately not accurate. As CMS stated in the rule, the agency has broad authority to permanently authorize additional telehealth services for payment within the context of the Medicare Physician Fee Schedule.

Crucially, however, CMS lacks the authority to permanently waive the originating site and site-of-service requirements that have been waived during the PHE. This means that Medicare telehealth services will once again be substantially limited to rural patients who visit qualified "originating sites" once the PHE ends. And, with those geographic restrictions and originating

site requirements reinstated, the expansion of telehealth under Medicare that we've seen throughout the pandemic would come to screeching halt.

It is therefore critical that Congress enact legislation to permanently remove the geographic restrictions and originating site requirements that have hampered access to telehealth services under Medicare for far too long. This has become a national priority for medical societies across the nation, including the FMA and AMA. Congressional legislation will similarly be required to provide for uniform reimbursement requirements across all payors, including those that are exempt from state regulation under the federal ERISA statute.

In short, while CMS is taking action to make limited elements of its recent expansion of telehealth services permanent, the most significant changes will require Congressional action. The FMA will continue to closely monitor the federal regulatory and legislative processes and strenuously advocate for changes that permanently expand and sensibly build upon the important telehealth flexibilities that have been offered to patients throughout the PHE.

More to come

As we mentioned at the beginning of this article, CMS' Final Rule comes in at an utterly voluminous 2,165 pages. While many provisions of the Final Rule are similar to what was originally proposed, we are carefully reading through each page so that we can summarize and share everything our members need to know in the coming days.

In the meantime, if you're looking for a summary of the rule or would like to read its contents for yourself, CMS has developed a comprehensive Fact Sheet that is available here. It includes a link to the PDF version of the Final Rule below.

Table 106 Estimated Impact of the Final Rule on Total Allowed Medicare Part B Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
ALLERGY/IMMUNOLOGY	$247	5%	4%	0%	9%
ANESTHESIOLOGY	$2,020	-6%	-1%	0%	-8%
AUDIOLOGIST	$75	-4%	-2%	0%	-6%
CARDIAC SURGERY	$266	-5%	-2%	0%	-8%
CARDIOLOGY	$6,871	1%	0%	0%	1%
CHIROPRACTOR	$765	-7%	-3%	0%	-10%

CLINICAL PSYCHOLOGIST	$832	0%	0%	0%	0%
CLINICAL SOCIAL WORKER	$857	0%	1%	0%	1%
COLON AND RECTAL SURGERY	$168	-4%	-1%	0%	-5%
CRITICAL CARE	$378	-6%	-1%	0%	-7%
DERMATOLOGY	$3,767	-1%	0%	0%	-1%
DIAGNOSTIC TESTING FACILITY	$748	-1%	-2%	0%	-3%
EMERGENCY MEDICINE	$3,077	-5%	-1%	0%	-6%
ENDOCRINOLOGY	$508	10%	5%	1%	16%
FAMILY PRACTICE	$6,020	8%	4%	0%	13%
GASTROENTEROLOGY	$1,757	-3%	-1%	0%	-4%
GENERAL PRACTICE	$412	5%	2%	0%	7%
GENERAL SURGERY	$2,057	-4%	-2%	0%	-6%
GERIATRICS	$192	1%	1%	0%	3%
HAND SURGERY	$246	-2%	-1%	0%	-3%
HEMATOLOGY/ONCOLOGY	$1,707	8%	5%	1%	14%
INDEPENDENT LABORATORY	$645	-3%	-2%	0%	-5%
INFECTIOUS DISEASE	$656	-4%	-1%	0%	-4%
INTERNAL MEDICINE	$10,730	2%	1%	0%	4%
INTERVENTIONAL PAIN MGMT	$936	3%	3%	0%	7%
INTERVENTIONAL RADIOLOGY	$499	-3%	-5%	0%	-8%
MULTISPECIALTY CLINIC/OTHER PHYS	$153	-3%	-1%	0%	-3%
NEPHROLOGY	$2,225	4%	2%	0%	6%
NEUROLOGY	$1,522	3%	2%	0%	6%
NEUROSURGERY	$811	-4%	-2%	-1%	-6%
NUCLEAR MEDICINE	$56	-5%	-3%	0%	-8%
NURSE ANES / ANES ASST	$1,321	-9%	-1%	0%	-10%
NURSE PRACTITIONER	$5,100	5%	3%	0%	7%

OBSTETRICS/GYNECOLOGY	$636	4%	3%	0%	7%
OPHTHALMOLOGY	$5,343	-4%	-2%	0%	-6%
OPTOMETRY	$1,359	-2%	-2%	0%	-4%
ORAL/MAXILLOFACIAL SURGERY	$79	-2%	-2%	0%	-4%
ORTHOPEDIC SURGERY	$3,812	-3%	-1%	0%	-4%
OTHER	$48	-3%	-2%	0%	-5%
OTOLARNGOLOGY	$1,271	4%	3%	0%	7%
PATHOLOGY	$1,265	-5%	-4%	0%	-9%
PEDIATRICS	$67	4%	2%	0%	6%
PHYSICAL MEDICINE	$1,164	-3%	0%	0%	-3%
PHYSICAL/OCCUPATIONAL THERAPY	$4,973	-4%	-4%	0%	-9%
PHYSICIAN ASSISTANT	$2,901	5%	2%	0%	8%
PLASTIC SURGERY	$382	-4%	-3%	0%	-7%
PODIATRY	$2,133	-1%	0%	0%	-1%
PORTABLE X-RAY SUPPLIER	$95	-2%	-4%	0%	-6%
PSYCHIATRY	$1,112	4%	3%	0%	7%
PULMONARY DISEASE	$1,654	0%	0%	0%	1%
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	$1,809	-3%	-3%	0%	-5%
RADIOLOGY	$5,275	-6%	-4%	0%	-10%
RHEUMATOLOGY	$548	10%	5%	1%	15%
THORACIC SURGERY	$352	-5%	-2%	0%	-8%
UROLOGY	$1,810	4%	4%	0%	8%
VASCULAR SURGERY	$1,293	-2%	-4%	0%	-6%
TOTAL	**$97,008**	**0%**	**0%**	**0%**	**0%**

* Column F may not equal the sum of columns C, D, and E due to rounding.