AMERICAN SOCIETY OF HEMATOLOGY
2021 L Street, NW, Suite 900, Washington, DC 20036 ph 202.776.0544 fax 202.776.0545 e-mail ASH@hematology.org

CY 2021 PHYSICIAN FEE SCHEDULE FINAL RULE SUMMARY

On December 1, the Centers for Medicare and Medicaid Services (CMS) released the Physician Fee Schedule Final Rule. Please see below for a summary of the areas of most importance to ASH members and click here for the CMS Fact Sheet.

Medicare Conversion Factor and Impact on Hematology/Oncology and E/M Services

- Conversion Factor (CF) set at $32.41 for 2021 – a 10% reduction from 2020 CF.

- According to CMS, the impact of the rule on Hematology/Oncology payments in aggregate is an increase of 14%, largely due to the increases in higher level evaluation and management (E/M) relative values and new E/M codes. The impact on individual physicians will be mixed based on their practice, as most procedural services and hospital-based services will see a decrease in Medicare payments of approximately 10% due to the conversion factor adjustment.

CMS finalized the changes to E/M descriptors, guidelines, and payment rates for 2021 as proposed in the 2020 MPFS Final Rule, including:

- History and exam will no longer be used to select the level of code for office/outpatient E/M visits. Instead, the history and exam components will only be performed when, and to the extent, reasonable and necessary, and clinically appropriate.
- Deletion of CPT code 99201.
- For levels 2 through 5 office/outpatient E/M visits, selection of the code level to report will be based on either the level of medical decision making (MDM) (as redefined by the new AMA/CPT guidance framework) or the total time personally spent by the reporting practitioner on the day of the visit.
- CMS is creating a new add-on code G2211 (.33 RVUs) - *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*. CMS is allowing the code to be reported with office/outpatient E/M for new and established patients. There are no restrictions on who can report the code, but CMS assumes that this code will be reported primarily by primary care and medical specialists.
- If time is used to determine the E/M code for office/outpatient E/M level 5 visits (99205 or 99215), CMS is establishing G2212 (.61 RVUs) - *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.* The code can be reported when the maximum time for the level 5 office/outpatient E/M visit is exceeded by at least 15 minutes on the date of service.

Telehealth Service Changes

While CMS is not extending most of the telehealth flexibilities and increased payments allowed during the public health emergency (PHE), in the final rule, it is creating a new audio only code G2252 (0.50

Work RVUs) to describe 11-20 minutes of medical discussion to determine the necessity of an in-person visit.

CMS is adding new permanent covered services under Telehealth Category 1 list (similar to telehealth services covered pre-PHE):

- Group Psychotherapy (CPT code 90853)
- Psychological and Neuropsychological Testing (CPT code 96121)
- Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99334-99335)
- Home Visits, Established Patient (CPT codes 99347-99348)
- Cognitive Assessment and Care Planning Services (CPT code 99483)
- Visit Complexity Inherent to Certain Office/Outpatient Evaluation and Management (E/M) (HCPCS code G2211)
- Prolonged Services (HCPCS code G2212)

CMS is adding new services under Category 3 (services added during the PHE on a temporary basis), which will remain covered through the calendar year in which the PHE ends:

- Home Visits, Established Patient (CPT codes 99349-99350)
- Emergency Department Visits, Levels 1-5 (CPT codes 99281-99285)
- Nursing facilities discharge day management (CPT codes 99315-99316)
- Psychological and Neuropsychological Testing (CPT codes 96130-96133 ; CPT codes 96136-96139)
- Therapy Services, Physical and Occupational Therapy, All levels (CPT codes 97161-97168; CPT codes 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)
- Hospital discharge day management (CPT codes 99238-99239)
- Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT codes 99469, 99472, 99476)
- Continuing Neonatal Intensive Care Services (CPT codes 99478-99480)
- Critical Care Services (CPT codes 99291-99292)
- End-Stage Renal Disease Monthly Capitation Payment codes (CPT codes 90952, 90953, 90956, 90959, 90962)
- Subsequent Observation and Observation Discharge Day Management (CPT codes 99217; CPT codes 99224-99226)

Supervision Requirements

Supervision of Residents in Teaching Settings through Audio/Video Real-Time Communications Technology

- CMS is finalizing a permanent policy to permit teaching physicians to meet the requirements to bill for their services involving residents through virtual presence, but only for services furnished in residency training sites that are located outside of an OMB-defined metropolitan statistical area (MSA). The medical record must clearly reflect whether the teaching physician was physically or virtually present at the training site during the key portion of the service.
- For all other settings, CMS is not permanently finalizing the teaching physician virtual presence policies; however, they will remain in place for the duration of the PHE to provide flexibility for communities that may experience resurgences in COVID-19 infections.

Virtual Teaching Physician Presence during Medicare Telehealth Services

- CMS is finalizing policy that Medicare may make payment under the PFS for teaching physician services when a resident furnishes Medicare telehealth services in a residency training site located outside of a MSA to a beneficiary who is in a separate location in the same rural area or is within a rural area outside of a different MSA, while a teaching physician is present, through interactive, audio/video real-time communications technology (excluding audio-only), in a third location, either within the same rural training site as the resident or outside of that rural training site.
- For all other settings, CMS is not permanently finalizing this policy; however, the policy will remain in place for the duration of the PHE for COVID-19 to provide flexibility for communities that may experience resurgences in COVID-19 infections.

National Coverage Determinations

CMS is finalizing removal of six outdated or obsolete National Coverage Determinations (NCDs). Removing outdated NCDs means Medicare Administrative Contractors no longer are required to follow those outdated coverage policies when it comes to covering services for beneficiaries. The result will allow flexibility for these contractors to determine coverage for beneficiaries in their geographic areas based on more recent evidence and information.

The three NCDs which ASH commented on are below:

- CMS finalized the removal of NCD # 20.5 Extracorporeal Immunoadsorption (ECI) using Protein A Columns (01/01/2001). ASH was supportive of this.
- CMS did not finalize the removal of NCD #110.14 Apheresis (Therapeutic Pheresis) (7/30/1992). ASH had supported the removal of this NCD.
- CMS did not finalize the removal of NCD #190.3 Cytogenetic Studies (7/16/1998). This was in line with ASH's position.