Summary of 2021 Changes to the Medicare Physician Fee Schedule, Quality Payment Program, and Other Federal Programs

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- Whether, outside of the circumstances of the PHE, there are increased concerns for patient safety if the service is furnished as a telehealth service;
- Whether, outside of the circumstances of the PHE, there are concerns about whether the provision of the service via telehealth is likely to jeopardize quality of care; and
- Whether all elements of the service could be fully and efficiently performed by a remotely located clinician using two-way, audio/video telecommunications technology.

A list of the temporary additions to the list of telehealth services is listed below:

Service Type	HCPCS	Long Descriptor

		key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.
Emergency Room Visits	99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision-making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor.
	99282	Emergency department visit for the evaluation and

Psychological and Neuropsychological Testing	96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
	96131	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure).
	96132	Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour.
	96133	Neuropsychological testing evaluation services by

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	90956	ESRD related services with 1 face-to-face visit per month; for patients 2-11 years
	90957	ESRD related services with 4 or more face-to-face visits per month; for patients 12-19 years
	90958	ESRD related services with 2-3 face-to-face visits per month; for patients 12-19 years
	90959	ESRD related services with 1 face-to-face visit per month; for patients 12-19 years
	90963	ESRD related services for home dialysis per full month; for patients younger than 2 years
	90964	ESRD related services for home dialysis per full month; for patients 2-11 years
	90965	ESRD related services for home dialysis per full month; for patients 12-19 years
	90966	ESRD related services for home dialysis per full month; for patients 20 years and older
	90967	ESRD related services for dialysis less than a full month of service; per day; for patients younger than 2 years
	90968	ESRD related services for dialysis less than a full month of service; per day; for patients 2-11 years
	90969	ESRD related services for dialysis less than a full month of service; per day; for patients 12-19 years
Complex Chronic Care Management Services	G2058	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month

Scope of Practice

Supervision of Diagnostic tests by Certain Non-Physician Practitioners (NPPs)

CMS is proposing to make permanent interim final policy during the PHE, which allowed supervision of diagnostic tests as permitted by state law and scope of practice by: Nurse Practitioners, Clinical Nurse S tacti r anc7Phh4.5 (s)9.6 (t)10.6 (o)-6.6 (nan)2.3 (o)-6.7 (fA)1 (as)1.3 (i)10.6 (o)ice2.6 ( )-3.2 (r)-3.4 (an)-3 (2.6-11.2 (sC

hospitals to provide and teaching physicians to bill for low to mid-level complexity outpatient E/M services when a teaching physician is not present. The Agency is also seeking comment on whether specific services added under the primary care exception should be extended temporarily or made permanent. CMS is soliciting public comment on whether these services should continue as part of the primary care exception once the PHE ends.

Additionally, CMS is considering whether, upon expiration of the PHE, the Agency should extend on a temporary basis some or all of the services added to the primary care exception list during the PHE and are soliciting public comment on whether these services should continue as part of the primary care exception after the PHE ends. CMS also notes that it is

Should this proposal be finalized, patients would be able to receive treatment for opioid overdose at an OTP and this medication would be included in the OTP Medicare benefit. CMS is also seeking feedback on whether the definition of OUD treatment services under the OTP benefit should be revised to include

Major MIPS flexibilities are summarized below. Additional policies are covered in other sections of this

a list of measures requiring a nine-month assessment period on the CMS website as soon as technically feasible, but no later than the beginning of the data submission period, which is January 2, 2021 for PY 2020.

As it does every year, CMS proposes changes to the measure inventory. In PY 2021, this would include "substantive changes" (i.e. changes to the specifications, title, and/or domain) to 112 measures, removal of 14 measures, and two new administrative claims measures. The hospital-wide 30-day all-cause unplanned readmission rate measure would replace the all-cause readmission measure and an additional administrative claims-based measure for hip/knee complications would be added. CMS notes that proposed changes reflect stakeholder recommendations for potential new specialty measure sets or revisions to existing specialty measure sets. In total, CMS proposes 206 measures for 2021. The summarized changes can be found in Appendix 1 of the proposed rule.

The new readmission measure would have a minimum of 200 cases and apply only to groups. The hip/knee complications measure would have a minimum of 25 cases and apply to individual clinicians and groups. In all other cases, case minimums would remain at 20. CMS proposes that different performance periods be considered on a case-by-case basis for administrative claims measures since they do not require active data reporting. The total hip/knee arthroplasty complications measure would have a three-year performance period that would start on Oct. 1 of the calendar year three years prior to the applicable performance year and conclude on Sept. 30 of the calendar year of the applicable performance year with a three-month numerator assessment period followed by a two-month claims run-out period.

For the 2021 CAHPS for MIPS Survey, CMS proposes to 1) add a new measure to assess patient-reported use of telehealth; and 2) add the following telehealth services to the listaltheavicesth

optional alternative to two existing measures: 1) Support Electronic Referral Loops by Sending Health Information; and 2) Support Electronic Referral Loops by Receiving and Incorporating Health Information. Clinicians may choose to report the two existing measures (and associated exclusions) or report the new measure. The new HIE Bi-Directional Exchange measure would be worth 40 points and reported via yes/no attestation. Clinicians who report the measure would attest to the following:

- "I participate in an HIE in order to enable secure, bi

CMS proposes to modify two existing IAs, changes for which are summarized in Appendix 2. In its March 31 IFR, CMS finalized a new IA that promotes clinician participation in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection. To receive credit for this clinical improvement, clinicians must report their findings through an open source clinical data repository or clinical data registry.

Cost Category (655)

For PY 2021 and subsequent performance periods, CMS proposes to include costs associated with telehealth services towards existing cost measures. Some telehealth services are already included, but the additional proposed codes were not originally included because they were newly added to the Medicare telehealth services list in the March 31 and May 8 Interim Final Rules (IFRs) or because they were not previously billed widely prior to the COVID-19 PHE. To view a full list of telehealth services proposed for inclusion for each cost measure, download the CMS zip file (codes are labeled 2020 but are correct).

Third Party Vendor Requirements (2458)

CMS proposes to codify that as a precondition of approval, all Qualified Clinical Data Registries (QCDRs) and qualified registries must conduct annual data validation audits for all performance categories and all submission types for which it reports data. Should any data deficiencies or errors arise, the vendor would be required to perform a targeted audit to identify root causes and correct any and all deficiencies prior to submitting data to CMS. Vendors would be required to provide the results of any and all audits, as well as clinical documentation to validate that the actions or outcomes measured actually occurred or were performed. When approving current and future vendor contracts, CMS proposes to consider whether vendors met these requirements in previous performance years, as well as whether they gave clinicians inaccurate or misleading information about QPP requirements. The Agency seeks comment on adding similar requirements for health IT vendors and CAHPS survey vendors, but proposes none. However, CMS does propose health IT vendors and CMS-approved survey vendors be required to participate in annual meetings and training calls as deemed necessary by CMS.

CMS had previously finalized that QCDRs must: 1) fully develop and test measures with complete results at the clinician level; and 2) collect data on all measures prior to submitting the measure starting with PY 2021 [illegible] C.3(fu)24.6 (flia.2 ( )]at)7.9 (.67g c);7.8 (c) (-e)-2 (4t)-2.9ita 72 (d (u)2.3 a)10.6 f(.62.2 (Tw5331.304 [-li Tw s)

APM Performance Pathway (APP) (626)

CMS proposes to terminate the MIPS APM Scoring Standard and replace it with the new APM Performance Pathway (APP) sta

would make the payment to another TIN. The Agency lays out an eight-step hierarchy based on varying degrees of APM participation, but in each case, the QP would have to be actively associated with that TIN(s) at the time of payment. Ultimately, CMS would disburse the APM Incentive Payment to any TIN(s) with which the QP is actively affiliated on the date payment is made, even if that TIN(s) is not affiliated with an APM in any way. The detailed step-by-step hierarchy can be found in the proposed rule. When CMS identifies multiple TINs at a single step, it would divide the payment proportionately based on the relative paid amount for Part B-covered professional services billed through each TIN. CMS proposes to issue a public notice requesting updated payment information for any QPs for which there are no active TINs to render payment, and for rare cases where a QP's payment was calculated solely based on supplemental services payments and no Medicare claims. The QPs identified in the public notice, or any

together with revised repayment mechanism documentation, in a form and manner and by a deadline specified by CMS, likely within 30 days from the date of the written notice from CMS.

Medicare Diabetes Prevention Program (MDPP) PHE Permanent Exceptions (581-591)

In the March 31 COVID-19 IFR