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2021 Medicare Physician Fee Schedule

Final Rule Summary

On Tuesday, December 1, 2020, the Centers for Medicare & Medicaid Services (CMS) issued the Medicare Physician Fee Schedule (MPFS) final rule with an estimated 5 percent cut to radiation oncology physician payments effective January 1, 2021. The final rule failed to provide relief from significant and unwarranted payment cuts as practice finances continue to reel from the effects of COVID-19.

The MPFS pays for services furnished by physicians and other practitioners in all sites of service. These services include visits, surgical procedures, diagnostic tests, therapy services, specified preventative services and more. Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for physician work, practice expense and malpractice. These RVUs become payment rates through the application of a Conversion Factor, which is updated annually.

MPFS Impact Table

The 2021 MPFS Impact Table (Table 106) shows the estimated effect on total allowed charges by specialty of all the RVU changes. CMS finalized a combined reduction of 5 percent on radiation oncology services. This significant cut can largely be attributed to previously finalized policies resulting in increases in the valuation of office/outpatient Evaluation and Management (E/M) visits, which constitute nearly 20 percent of total spending under the MPFS. These policies triggered a 10.2 percent reduction in the Conversion Factor to ensure budget neutrality to account for the shift in payment across all medical specialties due to the E/M modifications.

Table 106: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Radiation Oncology and Radiation Therapy Centers	$1,809	-3%	-3%	0%	-5%
Total	$97,008	0%	0%	0%	0%

Overall, those specialties that bill higher level established patient visits will see the greatest positive impact, as those codes were revalued at higher rates relative to the rest of the office/outpatient E/M code set. Physicians and other providers who do not primarily bill office-based E/M services, such as radiation oncology and radiology, are expected to see the greatest negative impact.

ASTRO is very disappointed in CMS' decision to move forward with the significant payment cuts despite efforts to urge the Agency to use its authority under the COVID-19 PHE to waive the statutorily mandated budget neutrality adjustment by at least a year. This would have allowed practices time to stabilize from significant losses already suffered in 2020 due to the pandemic.

ASTRO, in collaboration with other medical specialty groups, is advocating for Congress to include H.R. 8702, *the Holding Providers Harmless From Medicare Cuts During COVID-19 Act of 2020*, in any forthcoming health-related legislative package this year. Introduced by Rep. Ami Bera (D-CA) and Rep. Larry Bucshon (R-IN), this ASTRO-supported legislation would recognize the financial burden of the E/M cuts included in the final rule and provide a relief mechanism for radiation oncologists and other physicians who will see a cut in 2021. The relief would be distributed as a temporary additional payment in the amount of the difference between payments in 2020 and 2021 (for a 2-year period). ASTRO urges members to visit ASTRO's Advocacy Action Center so they may send a letter to their Representative urging them to co-sponsor this bill.

Conversion Factor/Target

The 2021 MPFS Conversion Factor, based on the finalized 2021 rates, is set at $32.41. This represents a decrease of $3.68 from the 2020 MPFS Conversion Factor rate update of $36.09. As previously mentioned, this 10.2 percent decline results from a statutorily mandated budget neutrality adjustment to account for changes in work RVUs.

Medicare Physician Conversion Factor (2016–2020)		
Year	CF	Update (%)
2017	$35.89	0.24%
2018	$36.00	0.31%
2019	$36.04	0.11%
2020	$36.09	0.14%
2021	$32.41	-10.20%

The table below demonstrates the impact of the Conversion Factor reduction on key radiation oncology services. Note that CMS finalized RVU increases for several key radiation oncology codes; however, the Conversion Factor reduction largely offset those increases:

CPT Code	MOD/SOS	CPT Descriptor	2020 National Rate	2021 Estimated National Rate	2021 Impact
77014	26	CT scan for therapy guide	$46.20	$41.16	-11%
77300	26	Radiation therapy dose plan	$33.56	$30.14	-10%
77301	26	Radiotherapy dose plan IMRT	$432.72	$389.24	-10%
77334	26	Radiation treatment aid(s)	$62.80	$56.07	-11%
77014		CT scan for therapy guide	$124.51	$117.97	-5%
77263		Radiation therapy planning	$174.31	$156.86	-10%
77290		Set radiation therapy field	$508.15	$474.81	-7%
77300		Radiation therapy dose plan	$67.85	$62.88	-7%
77301		Radiotherapy dose plan IMRT	$1,949.22	$1,826.95	-6%
77336		Radiation physics consult	$81.20	$79.08	-3%
77338		Design MLC device for IMRT	$497.32	$450.17	-9%
77373		SBRT delivery	$1,230.67	$1,114.26	-9%
77427		Radiation tx management x5	$196.33	$177.28	-10%
99205	NF	Office/outpatient visit new	$211.13	$210.99	0%
G6002		Stereoscopic x-ray guidance	$76.51	$72.60	-5%
G6012		Radiation treatment delivery	$262.74	$252.15	-4%
G6013		Radiation treatment delivery	$263.10	$252.80	-4%
G6015		Radiation tx delivery IMRT	$369.92	$366.88	-1%

2021 Office/Outpatient Evaluation and Management (E/M) Visits

In the 2020 MPFS final rule, CMS previously finalized modifications to the E/M code-set, including the creation of five levels of coding for established patients, reducing the number of levels to four for new patients, and revising the code definitions. The finalized changes allow

clinicians to choose the E/M visit level based on either medical decision-making or time and require the collection of medical history and exam **only** when medically appropriate. CMS also adopted the AMA's RUC-recommended payment rates and finalized payments based on each code descriptor to pay for each level of service, rather than utilizing a "blended rate" for E/M code levels 2 through 4 that was finalized in the 2019 MPFS final rule.

Table 20 from the 2021 MPFS Final Rule depicted below shows the new E/M Code set that is effective January 1, 2021:

TABLE 20: Summary of Codes and Work RVUs Finalized in the CY 2020 PFS Final Rule for CY 2021

HCPCS Code	Current Total Time (mins)	Current Work RVU	CY 2021 Total Time (mins)	CY 2021 Work RVU
99201	17	0.48	N/A	N/A
99202	22	0.93	22	0.93
99203	29	1.42	40	1.6
99204	45	2.43	60	2.6
99205	67	3.17	85	3.5
99211	7	0.18	7	0.18
99212	16	0.48	18	0.7
99213	23	0.97	30	1.3
99214	40	1.5	49	1.92
99215	55	2.11	70	2.8
G2212	N/A	N/A	15	0.61
G2211	N/A	N/A	11	0.33

HCPCS add-on code G2211

In the 2021 MPFS final rule, CMS finalized HCPCS code G2211 "*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. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)"* to be implemented January 1, 2021 to better describe the work associated with visits that are part of ongoing, comprehensive primary care and/or visits that are part of ongoing care related to a patient's single, serious, or complex chronic condition.

In response to concerns from medical specialty societies regarding the lack of clarity on its use, CMS revised the code descriptor to clarify that G2211 applies to a single condition that is serious, rather than any single condition. In addition, CMS refined the utilization assumptions originally proposed for this code. In the MPFS proposed rule, CMS assumed that this code would be reported with 100 percent of office/outpatient E/M visits by specialties that rely on office/outpatient E/M visits to report the majority of their services. The Agency reduced that estimate to 90 percent in the final rule.

HCPCS add-on code G2212

CMS is finalizing the application of HCPCS code G2212 *"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 (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) "(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes))" in combination with either 99205 or 99215 (Level 5 – Office E/M Visit or Outpatient E/M Visit) when the actual time of the reporting physician or Non-Physician Provider (NPP) exceeds the maximum allotted time by at least 15 minutes on the date of service. The allotted time for 99205 is 85 minutes and the allotted time for 99915 is 70 minutes; therefore, the Prolonged Office/Outpatient E/M Visit code could be used for visits that exceed those allotted times by 15 minutes.

Tables 26 and 27 below provides examples on the total time requirement for reporting in prolonged office/outpatient E/M visits.

******Note: HCPCS code G2212 was finalized in the 2021 MPFS final rule to replace CPT code 99417. CMS expressed that the use of CPT code 99417 was unclear when the minimum required time for the level 5 visit is exceeded by at least 15 minutes and would result in double counting time.***

TABLE 26: Proposed Prolonged Office/Outpatient E/M Visit Reporting - New Patient

CPT Code(s)	Total Time Required for Reporting*
99205	60-74 minutes
99205 x 1 and 99417 x 1	89-103 minutes
99205 x 1 and 99417 x 2	104-118 minutes
99205 x 1 and 99417 x 3 or more for each additional 15 minutes.	119 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

TABLE 27: Proposed Prolonged Office/Outpatient E/M Visit Reporting – Established Patient

CPT Code(s)	Total Time Required for Reporting*
99215	40-54 minutes
99215 x 1 and 99417 x 1	69-83 minutes
99215 x 1 and 99417 x 2	84- 98 minutes
99215 x 1 and 99417 x 3 or more for each additional 15 minutes.	99 or more

*Total time is the sum of all time, including prolonged time, spent by the reporting practitioner on the date of service of the visit.

ASTRO expects radiation oncologists to bill HCPCS codes G2211 and G2212 given the complexity of most radiation oncology patients.

<u>Proton Beam Treatment Delivery (CPT codes 77520, 77522, 77523, and 77525)</u>

In April 2018, the AMA RUC's Relativity Assessment Workgroup (RAW) identified CPT code 77522 (Proton treatment delivery; simple, with compensation) and CPT code 77523 (Proton treatment delivery; intermediate) as contractor-priced Category I CPT codes with 2017 estimated Medicare utilization of over 10,000 services. Although the RAW agreed with ASTRO that this family of codes should remain contractor priced, the RUC determined that these services should be surveyed to assess practice expense (PE). CPT codes 77520 (Proton treatment delivery; simple, without compensation) and 77525 (Proton treatment delivery; complex) were added to the code family and the group was surveyed for PE for the April 2019 RUC meeting where the PE subcommittee approved ASTRO's recommended direct PE inputs without refinement.

In the proposed 2021 MPFS, CMS reported that it encountered significant difficulties in reviewing the recommended direct PE inputs for the codes in the Proton Beam Treatment Delivery family. These difficulties were largely associated with determining a price for the two new equipment items in the code family, the "Proton Treatment Vault" (ER115) and the "Proton Treatment Delivery System" (ER116). These equipment items had extraordinarily high prices of $19,001,914 and $30,400,000, respectively, on the invoices submitted with the code family. By way of comparison, the highest equipment price in the CMS database for 2021 is the "SRS system, Linac" (ER082) equipment item, valued at $4,233,825. CMS expressed concern that establishing equipment pricing for the proton treatment vault and delivery system at a rate that is so much higher than anything else in the equipment database could distort relativity within the fee schedule. Therefore, the Agency proposed continuing carrier pricing for the proton beam treatment delivery codes. Although ASTRO supported the RUC's direct practice expense recommendations for proton services, we also recognized the Agency's decision to carefully consider the unintended consequences of pricing high equipment cost items using the current CMS methodology, particularly because contractor pricing would allow proton therapy providers to adapt quickly to shifts in the market-based costs associated with the proton treatment equipment.

In the 2021 MPFS final rule, CMS is finalizing its decision to maintain contractor pricing for CPT codes 77520, 77522, 77523, and 77525, instead of proposing active pricing for these services. CMS asserts that maintaining contractor pricing will allow proton therapy providers to adapt more quickly to shifts in the market-based costs associated with the proton treatment equipment. Additionally, the Agency believes that these frequent changes can be more accurately captured through contractor pricing, as opposed to the need to update the pricing of the proton treatment equipment on an annual basis.

Radiation Treatment Delivery (CPT code 77401)

CPT code 77401 (Radiation treatment delivery, superficial and/or ortho voltage, per day) was identified by the RUC RAW through a screen of high-volume growth, for services with 2017 Medicare utilization of 10,000 or more that has increased by at least 100 percent from 2012 through 2017. In January 2019, the RUC recommended referring this service to the CPT Editorial Panel to better define the set of services associated with delivery of superficial radiation therapy (SRT). In the 2021 MPFS proposed rule, CMS proposed the following direct PE values refinements: a reduction of 2 minutes for the clinical labor task CA024: "Clean room/equipment

by clinical staff," to the standard 3 minutes, and CMS proposed to exclude new equipment item ER119 "Lead Room." After consideration of public comments, the Agency is finalizing the direct PE inputs for 77401 without refinement. CPT code 77401 is a PE only code.

Medical Physics Dose Evaluation (CPT code 76145)

CPT code 76145 describes the medical physics dose calculation that exceeds institutional review when an exposure threshold is met. The CPT Editorial Panel created CPT code 76145 (*Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report*), which is a new PE only code. This code is primarily intended for use in a non-facility setting. A multispecialty group conducted a PE-only survey, which included several experts familiar with the service to evaluate the survey results. The consensus panel then developed direct PE recommendations and presented them to the RUC PE subcommittee. This code was developed through a PE-only survey by specialty societies due to the high amount of clinical staff time associated with the service and the fact that there are no analogous comparable services. Additionally, the Editorial Panel stated that the service is stand-alone, meaning that the medical physicist works independently from a physician and there are no elements of the PE that are informed by time that would benefit from a physician work survey. ASTRO supported the PE survey inputs and clinical staff time resulting from the survey.

In the MPFS final rule, CMS is finalizing the RUC-recommended direct PE inputs for CPT code 76145 and removing this code from the "DRA cap," also known as the "OPPS cap," which would cap the payment for the technical component (TC) of the procedure based on the Outpatient Prospective Payment System (OPPS) payment.. Typically the cap is applied to diagnostic services, however because the code is more similar to physics consultation services like those described by CPT codes 77331 (*Special dosimetry (e.g., TLD, microdosimetry) (specify), only when prescribed by the treating physician*), 77336 (*Continuing medical physics consultation, including assessment of treatment parameters, quality assurance of dose delivery, and review of patient treatment documentation in support of the radiation oncologist, reported per week of therapy*), and 77370 (*Special medical radiation physics consultation*), CMS is not moving forward with including CPT code 76145 within the codes that are subject to the OPPS cap.

Direct PE Inputs for Supply and Equipment Pricing – Year Three of Four-Year Phase-In

In the 2019 MPFS final rule, CMS worked with market-research company StrategyGen to conduct an in-depth and robust market research study to update the PFS direct PE inputs (DPEI) for supply and equipment pricing. CMS update the Direct Practice Expense (PE) inputs for the pricing for over 2,000 supply and equipment items (1,300 supplies and 750 equipment items), including key equipment items related to radiation oncology. To address significant changes in payment, CMS phased in the new direct PE inputs over a four-year period. ASTRO opposed these proposed changes and helped to mitigate some of the initially proposed reductions.

PE input pricing for the affected equipment items in 2021 will be based on 75 percent of the new pricing and 25 percent of the old pricing. It remains important to monitor how the updated

pricing impacts payment. The following table details those radiation oncology equipment items that will experience the greatest decline in reimbursement in 2021 because of this policy.

	2019 Price	**2020 Price**	**2021 Price**
ED033 Treatment Planning System, IMRT (Corvus w-Peregrine 3D Monte Carlo)	$312,221	$273,896	$235,572
ER003 HDR Afterload System, Nucletron - Oldelft	$314,394	$253,787	$193,181
ER083 SRS System, SBRT, Six Systems, Average	$3,743,430	$3,486,861	$3,230,291

As anticipated, the continuation of the modification to the prices for specific supplies and equipment has a negative impact on the PE RVUs for several radiation oncology services. According to the final MPFS, CMS will continue to welcome the submission of invoices with additional information regarding the pricing of these equipment items in future rulemaking.

Telehealth and Other Services Involving Communications Technology

In the 2021 MPFS final rule, CMS is finalizing several changes to the Medicare telehealth services list. One of the key changes implemented through COVID-19 waivers established in interim final rules issued during the PHE were expanded flexibility for telehealth services.

For 2021, CMS is permanently keeping several codes that radiation oncologists typically bill on the Medicare telehealth list following the PHE, including the prolonged office and outpatient E/M visit codes. However, CMS will no longer include Radiation Treatment Management Services (CPT code 77427) on the telehealth list after the expiration of the PHE. The Agency expressed concern over whether the elements described by CPT code 77427 could, in most cases, be furnished in full via two-way, audio-video communication technology. Additionally, the Agency agreed with ASTRO that face-to-face engagement between radiation oncologists, clinical treatment teams, and patients under treatment is the ideal and most appropriate way to manage care.

Continuation of Payment for Audio-only Visits

CMS established separate payment for audio-only telephone E/M services (CPT codes 99441, 99442, and 99443) during the PHE, and cross-walked payment rates for these services from office/outpatient E/M codes. CMS received feedback from stakeholders that the use of audio-only services was more prevalent than expected, especially because many beneficiaries were not utilizing video-enabled communication technology from their homes. Since the statute requires telehealth services to have a two-way, audio/video communication technology, CMS states that it does not have the authority to extend this flexibility beyond the PHE. In the 2021 MPFS final rule, CMS recognizes the value of audio-only services given the widespread support for the

continuing need for audio-only conversations with patients and the Agency is establishing additional coding and payment for an extended audio-only assessment service on an interim basis for CY 2021. ASTRO supports the continued reimbursement of audio-only services as cancer patients have benefited from the use of audio-only codes, particularly for those who lack access to audio/video capable devices. In addition, the prevalent use of audio-only codes necessitates their continued separate reimbursement, particularly during the COVID-19 PHE.

For CY 2021, on an interim basis, CMS is establishing HCPCS code G2252 (*Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.*). G2252 will have a direct crosswalk to CPT code 99442, the value which most accurately reflects the resources associated with a longer service delivered via synchronous communication technology, which can include audio-only communication.

Direct Supervision by Interactive Telecommunications Technology

For the duration of the COVID-19 PHE, CMS adopted an interim final policy revising the definition of direct supervision to include virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology. In the 2021 MPFS final rule, CMS finalized its decision to allow direct supervision to be provided using real-time, interactive audio and video technology (excluding telephone that does not also include video) through the end of the PHE or December 31, 2021, whichever comes later.

This allows for the continued use of virtual presence of the supervising physician or practitioner using interactive audio/video real-time communications technology recognizing that in some cases, the physical proximity of the physician or practitioner might present additional infection exposure to the patient and/or practitioner. In the 2021 MPFS final rule, CMS clarifies that the direct supervision requirement can be met by the supervising physician being immediately available to engage via audio/video technology and would not require real-time presence or observation of the service via interactive audio and video technology throughout the performance of the procedure. According to CMS, individual practitioners are in the best position to make decisions about how to meet the requirement to provide appropriate direct supervision based on their clinical judgement in certain circumstances. ASTRO has additional information regarding the PHE supervision policy posted on its website.

Additionally, in the 2021 MPFS final rule, CMS is finalizing policy revisions related to the scope of practice for physician fee schedule services that would allow NPs, CNSs, PAs, and CNMs to provide the appropriate level of supervision assigned to diagnostic tests, to the extent authorized under State law and scope of practice. In accordance with statute, these NPPs would be working either under physician supervision or in collaboration with a physician. According to CMS, this flexibility is designed to increase the capacity and availability of practitioners who can supervise

diagnostic tests, which would alleviate some of the demand on physicians as the only source to perform this specific function.

ASTRO provided CMS with comments expressing concern about patient safety related to this policy. ASTRO has long expressed that the existing supervision levels associated with IGRT services (i.e., codes G6001 (previously 76950), 77014, G6002 (previously 77421), and 76965) should remain in place and require the physician's presence and participation due to the irreversible nature of radiation therapy. Despite these concerns, the Agency did not feel compelled to change the scope of practice policy for 2021.

Quality Payment Program

ASTRO will provide a separate summary on the provisions in the rule regarding updates to the Quality Payment Program (QPP) including changes to the Merit Based Incentive Payment System (MIPS) and Alternative Payment Models (APMs).

Additional information about the 2021 MPFS final rule can be found at the following links:

To view the 2021 Physician Fee Schedule final rule, please visit:

https://www.cms.gov/files/document/12120-pfs-final-rule.pdf

For a fact sheet on the 2021 Physician Fee Schedule final rule, please visit:

https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year-1