“Each year’s regrets are envelopes in which messages of hope are found for the new year.”

-- John R. Dallas, Jr.

Client Memo
January 2021

NEWS Update

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2021 Physician Fee Schedule

The 2021 Medicare Physician Fee Schedule (MPFS) Final Rule was placed on display at the Federal Register on December 2, 2020. This final rule updates payment policies, payment rates, and other provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2021.

This final rule updates policies affecting the calculation of payment rates and includes misvalued codes. It also adds services to the telehealth list including a third temporary category for services added under the PHE, as well as certain other revisions to telehealth services. It also addresses direct supervision as it relates to interactive technology, payment for teaching physicians, and provides clarification on medical record documentation.

Additionally, this final rule includes several regulatory actions regarding professional scope of practice for certain non-physician practitioners. This final rule also provides clarification to the implementation of Section 2005 of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act, which creates a new Medicare Part B benefit for Opioid Treatment Programs.

The 2021 PFS final rule is one of several rules that reflect a broader Administration-wide strategy to create a health-care system that results in better accessibility, quality, affordability, empowerment, and innovation.

For details on the final rule, please see the CMS fact sheet which can be viewed by going to:

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

Reactions to 2021 Physician Pay Rule

Medicare officials stuck with their plan to increase payments for office visits for primary care and several other specialties that focus on helping patients manage complex conditions such as diabetes. In doing so, Medicare also finalized cuts for other fields, triggering a new wave of protests, writes Kerry Dooley in his December 2, 2020, article “Medicare Finalizes 2021 Physician Pay Rule With E/M Changes,” for *Medscape Medical News.*

The most contentious item proposed for 2021 was a reshuffling of payments among specialties as part of an overhaul of Medicare's approach to valuing E/M services.

There was broader support for other aspects of the E/M overhaul, which are intended to cut some of the administrative hassle clinicians face.

Specialties in line for increases under the 2021 final physician fee schedule include allergy/immunology (9%), endocrinology (16%), family practice (13%), general practice (7%), geriatrics (3%), hematology/oncology (14%), internal medicine (4%), nephrology (6%), physician assistants (8%), psychiatry (7%), rheumatology (15%), and urology (8%).

In line for cuts would be anesthesiology (-8%), cardiac surgery (-8%), emergency medicine (-6%), general surgery (-6%), infectious disease (-4%), neurosurgery (-6%), physical/occupational therapy (-9%), plastic surgery (-7%), radiology (-10%), and thoracic surgery (-8%).

Many physician groups sought to waive a "budget-neutral" approach to the E/M overhaul, which makes the offsetting of cuts necessary. They argue this would allow increased compensation for clinicians whose practices focus on office visits without requiring offsetting cuts from other fields of medicine.

The AMA is among those urging Congress to prevent or postpone the payment reductions resulting from Medicare's budget neutrality requirement as applied to the E/M

overhaul. AMA President, Susan R. Bailey, MD, noted that many physicians are facing "substantial economic hardships due to COVID-19."

The Surgical Care Coalition, which represents about a dozen medical specialty associations, asked members of Congress to block the full implementation of the E/M overhaul from going into effect on January 1, 2021.

There also are champions for the approach CMS took in the E/M overhaul. The influential Medicare Payment Advisory Commission (MedPAC) has argued strongly for keeping the budget-neutral approach to the E/M overhaul.

MedPAC Chairman Michael E. Chernew, PhD, said this approach would "help rebalance the fee schedule from services that have become overvalued to services that have become undervalued. This budget-neutral approach also will go further in reducing the large gap in compensation between primary care physicians and specialists such as surgeons."

The American Academy of Family Physicians (AAFP) joined ACP in a November 30th letter to congressional leaders, urging them to allow Medicare to increase investment in primary care, benefiting millions of Medicare patients and the program itself, and reject last minute efforts to prevent these essential and long-overdue changes from going fully into effect on January 1, 2021.

COVID-19 Bill Impacts 2021 MPFS

Congress released the text of its 5,593-page COVID-19 Stimulus legislation that includes an extension of federal funding through the remainder of the fiscal year, $900 billion in new COVID-19 relief, and "surprise" medical bill protections, among other things, reported *HBMA* in its December 21, 2020 bulletin: "Quick Summary of COVID-19 Stimulus Legislation." Here are several highlights of what is included:

Medicare Physician Fee Schedule Changes

The bill provides a three-month delay to the 2% Medicare Sequestration reduction to Medicare payments that was set to resume on January 1, 2021.

The 2% payment Sequestration is suspended through March 31, 2021 and applies to all Medicare Fee-For-Service claims since May 1, 2020.

The bill provides a 3.75% increase to the Medicare Physician Fee Schedule (PFS) payments in 2021. This is intended to help providers impacted by payment reductions due to the budget neutrality requirement associated with new E/M code values and documentation requirements.

This adjustment, however, applies to all providers, including those who are projected to receive an increase due to the E/M changes. This adjustment is paid for from the Medicare trust fund.

The bill also prohibits Medicare from paying HCPCS code G2211 (Visit Complexity Inherent to Certain Office/ Outpatient Evaluation and Management) prior to January 1, 2024.)

G2211 on hold for 3 years!

The E/M add on code was meant to compensate physicians and other qualified health care professionals for the inherent complexity of primary care and other office visits.

G2211 was expected to be frequently utilized in 2021. CMS included this code in its estimated impacts of the E/M changes. With Congress delaying Medicare coverage for this code, CMS will likely need to update its E/M spending estimates which could impact other services that are affected by budget neutrality caused by the 2021 E/M code changes.

Provider Relief Fund

The bill provides $3 billion in additional grants to hospital and health care providers for healthcare-related expenses or lost revenue directly attributable to the coronavirus. It also directs HHS to allocate not less than 85% of unobligated funds in the Provider Relief Fund through an application-based portal to reimburse health care providers for financial losses incurred in 2020.

Paycheck Protection Program (PPP)

The bill creates a second PPP loan opportunity, called a "PPP second draw" loan, with a maximum loan amount of $2 million. To receive a second PPP loan, eligible entities must:

- Employ not more than 300 employees;
- Have used or will use the full amount of their first PPP; and
- Demonstrate at least a 25% reduction in gross receipts in the first, second, or third quarter of 2020 relative to the same 2019 quarter.

The bill also makes the following expenses allowable and forgivable for PPP funds:

- Payment for any software, cloud computing, and other human resources and accounting needs.
- Expenditures to a supplier pursuant to a contract, purchase order, or order for goods in effect prior to taking out the loan that are essential to the recipient's operations at the time at which the expenditure was made.
- Personal protective equipment and adaptive investments to help a loan recipient comply with federal health and safety guidelines or any equivalent state and local guidance related to COVID-19 during the period between March 1, 2020, and the end of the national emergency declaration

Surprise Medical Bills

The stimulus includes a newly revised version of the No Surprises Act, which protects patients from unexpected out-of-network (OON) "surprise" medical billing scenarios and establishes a process for resolving reimbursement disputes between the patient's health plan and the OON provider in these scenarios.

Surprise medical bills typically refer to scenarios where a patient receives care from an out-of-network provider at an in-network hospital. The bill also applies to OON air ambulance services.

The bill protects patients from high OON bills by limiting what patients have to pay out-of-pocket (OOP) in surprise scenarios to no more than their in-network cost-sharing amount. Providers would not be able to balance bill patients for anything more than their in-network cost-sharing amount.

COVID-19 Bill Includes Some Offsets to Part B Cuts Scheduled for Next Year --

Maggie Flynn, *Skilled Nursing News, December 22, 2020*

The new spending bill passed by Congress on December 21, 2020, contains some respite for cuts to Medicare Part B that posed a significant threat to therapy operations in skilled nursing facilities.

Although nursing home provider groups expressed disappointment that the bill did not go further in providing direct aid for long-term care, it does contain some offsets to cuts to the physician fee schedule for 2021 that threatened to reduce Medicare Part B therapy payment rates.

The 3-year delay of the complexity code G2211, which is part of CMS's E/M reform has caused CMS to recalculate the conversion factor and take into account the savings from the delay of this code. Congressional summaries estimate it will mitigate about one third of the E/M related cuts.

The cuts to the physician fee schedule would have resulted in a reduction of about 9% to Medicare Part B reimbursement for physical therapy (PT) and occupational therapy (OT), with cuts associated with speech therapy as well.

Overview of 2021 E&M Changes

Stuart Newsome, CPCO and Stacey LaCotti with Waystar, a healthcare revenue cycle management company, summarize the 2021 E&M Changes in their presentation "Preparing for 2021 E&M Guideline Changes."

CMS and the AMA worked together to meet the following objectives:

- Reduce administrative burden
  - Decrease documentation in medical record that is not needed for patient care
- Improve payment accuracy
  - Revaluing E&M codes as well add-on codes
  - Reversed the flat rate concept
  - Increasing RVUs for E&M
- Update code set definitions
  - Simplified code selection criteria
  - Created consistency with detailed guidelines
  - Aligned guidelines with CPT descriptors

IMPORTANT!

* Changes effective January 1, 2021
* Only applies to office/other outpatient E&M visits
* Other E&M services are not affected
  - Hospital observation/inpatient
  - Emergency
  - Consultations
  - Nursing homes/facilities
  - Home services

History and Physical Exam

- Eliminate history and exam as elements for code selection
- Both still need to be documented -- contributes to both time calculations and MDM but should not be the only factors in determining a level

- Code descriptions updated to indicate providers should perform a “medically appropriate history and/or examination”

New Patient

Code	New Description
99201	Deleted – use 99202
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a **medically appropriate history and/or examination and straightforward medical decision making**. When using time for code selection, **15-29 minutes** of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a **medically appropriate history and/or examination and low level of medical decision making.** When using time for code selection, **30-44 minutes** of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a **medically appropriate history and/or examination and moderate level of medical decision making**. When using time for code selection, **45-59 minutes** of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a **medically appropriate history and/or examination and high level of medical decision making**. When using time for code selection, **60-74 minutes** of total time is spent on the date of the encounter.

Established Patient

Code	New Description
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires **a medically appropriate history and/or examination and straightforward medical decision making**. When using time for code selection, **10-19 minutes** of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a **medically appropriate history and/or examination and low level of medical decision making**. When using time for code selection, **20-29 minutes** of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a **medically appropriate history and/or examination and moderate level of medical decision making**. When using time for code selection, **30-39 minutes** of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a **medically appropriate history and/or examination and high level of medical decision making**. When using time for code selection, **40-54 minutes** of total time is spent on the date of the encounter.

Document based on Time or MDM

- **Cannot use both – one or the other!**
- **Rules for time-based coding**
  - Current criteria only utilizes time when the coordination and counseling of care is greater than 50% of the visit
  - Counseling/coordination is no longer required
  - Definition of time is *minimum* time, not *typical* time
  - Represents total provider time on the date of service
    - Builds on Medicare’s movement to better recognize the work involved in non-face-to-face services like care coordination

Time-Based Coding

- **Total time documented includes**
  - Total time on date of encounter
  - Both face-to-face and non-face-to-face time
  - Activities by physician or qualified healthcare professional (but not clinical staff)

*** not separately reported**

> **Is the documentation of time required in the note or is that a guide for providers?**
>
> Yes, the time must be recorded in the note and should reflect the time the physician spent with the patient and the activities that count toward total time.

Pitfalls of Time-based Coding

- Purpose is to allow for extenuating circumstances
- Increases chances of audit with high frequency
- **Make sure time adds up!**
  - Do not code for more time than the provider has in their day (adjust official hours of operation to cover total hours worked)
  - Have realistic time allocations

Revised Prolonged Services Code

- **New Codes**
  CPT 99417 – AMA (Commercial)
  HCPCS G2212 – CMS (Medicare/Medicare Adv)
- Only available for **time-based coding**
- Use when level 5 code is exceeded by 15 minutes (99205,99215)
- Use with 99205 and 99215 only
- **Cannot be used with MDM**

CMS and AMA treat prolonged services differently:

The AMA released the new prolonged service CPT code 99417 on September 1, 2020. In the 2021 Final Rule, CMS indicated that the AMA coding guidelines for CPT 99417 were unclear because the description indicates the code should be used when the service **is beyond the minimum required time** of the primary procedure. Therefore, CMS released HCPCS code G2212 which should be used when the service is **beyond the maximum required time** of the primary procedure.

Both the CPT 99417 and HCPCS G2212 can only be used as an add-on to 99205 and 99215 and only when time is used as the criteria for code selection.

99417 – AMA code to be used when the service is beyond the **minimum** required time of the primary procedure

G2212 – CMS code to be used when the service is beyond the **maximum** required time of the primary procedure.

Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, or 99416. Do not report G2212 for any time unit less than 15 minutes

AMA and CMS Comparison Between Total Practitioner Times for Office/Outpatient E&M Visits

New Pt Practitioner Total Time	AMA – Prolonged Service CPT Code Use
60-74 Minutes	99205
75-89 Minutes	99205 x 1 and 99417 x 1
90-104 Minutes	99205 x 1 and 99417 x 2
105 Minutes or More	99205 x 1 and 99417 x3 or more for each addt'l 15 minutes
New Pt Practitioner Total Time	**CMS – Prolonged Service HCPCS Code Use**
60-74 Minutes	99205
89-103 Minutes	99205 x 1 and G2212 x 1
104-118 Minutes	99205 x 1 and G2212 x 2
119 Minutes or More	99205 x 1 and G2212 x 3 or more for each addt'l 5 minutes

Medical Decision-Making (MDM)

- Used current CMS Table of Risk as foundation
- Did not change the three current MDM subcomponent headings
- Removed ambiguous terms/concepts like "mild" or "acute or chronic illness with systemic symptoms" and defined important terms like "independent historian"
- Further redefined data elements to move away from adding up tasks
- Focuses on tasks that affect the management of the patient
- Quantified the numbers of tests ordered, tests reviewed, and/or notes and records reviewed
- Addresses the number and complexity of problems addressed

2021 Quality Payment Program Final Rule – courtesy of *MD Interactive's MIPS Blog*

On December 1, 2020, CMS published the final policies for the 2021 performance year of the Quality Payment Program (QPP) via the Medicare Physician Fee Schedule Final Rule.

The key highlights of the 2021 Final MIPS rule include:

- Delaying the MIPS Value Pathways (MVPs) implementation until 2022.
- Increasing the performance threshold from 45 points to 60 points for 2021 – **this means you must score at least 60 MIPS points to avoid a negative 9% penalty in 2023.**
- Revising performance category weights for Quality (decreases from 45% to 40%) and Cost (increases from 15% to 20%).

Performance Category	2021 Weight
Quality	40% (down from 45%)
Cost	20% (up from 15%)
Promoting Interoperability	25% (no change)
Improvement Activities	15% (no change)

Quality Performance Category – must continue to report 6 measures on at least 70% of your eligible patients for the entire year. At least 1 of the 6 measures should be an Outcome or High Priority measure.

2 new administrative claims measures added for 2021:

1) Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for MIPS Eligible Clinician Groups.
2) Risk-standardized complication rate (RSCR) following elective primary total hip arthroplasty (THA) and/or total knee arthroplasty (TKA) for MIPS Eligible Clinicians.

12 quality measures removed for 2021:

Quality Measures Removed in 2021	
#048	Urinary Incontinence: Assessment of Presence or Absence of Urinary Incontinence in Women Aged 65 Years and Older
#069	Hematology: Multiple Myeloma: Treatment with Bisphosphonates
#146	Radiology: Inappropriate Use of "Probably Benign" Assessment Category in Screening Mammograms
#333	Adult Sinusitis: Computerized Tomography (CT) for Acute Sinusitis (Overuse)
#348	Implantable Cardioverter-Defibrillator (ICD) Complications Rate
#390	Hepatitis C: Discussion and Shared Decision Making Surrounding Treatment Options
#408	Opioid Therapy Follow-up Evaluation
#412	Documentation of Signed Opioid Treatment Agreement
#414	Evaluation or Interview for Risk of Opioid Misuse
#435	Quality of Life Assessment For Patients With Primary Headache Disorders
#437	Rate of Surgical Conversion from Lower Extremity Endovascular Revascularization Procedure
#458	All-Cause Hospital Readmission (Administrative Claims measure)

Promoting Interoperability Performance Category

- Retained the Query of PDMP measure as an optional measure and makes it worth 10 bonus points.
- Added an optional Health Information Exchange (HIE) bidirectional exchange measure.
- Preserved the automatic reweighting policies for the following clinician types:
  - Nurse Practitioners (NPs)
  - Physician Assistants (PAs)
  - Certified Registered Nurse Anesthesiologists (CRNAs)
  - Clinical Nurse Specialists (CNSs)
  - Physical Therapists
  - Occupational Therapists
  - Qualified Speech-language Pathologist
  - Qualified Audiologists
  - Clinical Psychologists
  - Registered Dieticians or Nutrition Professionals

Cost Performance Category – CMS will maintain the existing Cost measures.

Improvement – there are no significant changes to this category. CMS removed IA_CC_5 CMS Partner in Patients Hospital Engagement Network and modified 2 activities for 2021:

- IA_BE_4 Engagement of patient through implementation of improvements in patient portal
- IA_AHE_7 Comprehensive Eye Exams

CMS will also continue the COVID-19 clinical data reporting Improvement Activity with a modification to the activity description. To receive credit for this improvement activity, a MIPS eligible clinician or group must:

- Participate in a COVID-19 clinical trial utilizing a drug or biological product to treat a patient with a COVID-19 infection and report their findings through a clinical data repository or clinical data registry for the duration of their study; or
- Participate in the care of patients diagnosed with COVID-19 and simultaneously submit relevant clinical data to a clinical data registry for ongoing or future COVID-19 research.

Complex Patient Bonus -- **For the 2020 performance year only,** CMS will double the complex patient bonus so that clinicians, groups and APM Entities can earn up to 10 bonus points (instead of 5 bonus points) to account for the additional complexity of treating their patient population due to COVID-19.

Web-Interface Reporting Will Sunset in 2022 -- CMS will end the CMS Web Interface reporting option for ACOs, registered groups and APM Entities beginning with the 2022 performance period.

MIPS APM Reporting Options -- MIPS eligible clinicians in APMs would be given the option to participate in MIPS and submit data at the individual, group, or APM Entity level. The APM Scoring Standard (reporting requirements and scoring approach for APM participants) will end beginning with the 2021 performance period.

For more information, please go to the Quality Payment Program website (https://qpp.cms.gov) and view the final rule.

Relaxed Telehealth Visit End Dates

No official word has yet been received on whether the COVID-19 public health emergency, due to end on January 20, 2021, will be extended another 90 days. End dates as of 12/30/20 are shown below. Please note that Aetna and UnitedHealthcare have extended their flexible telehealth rules until the end of the public health emergency. Cigna's Virtual Care Policy begins January 1, 2021. The 2021 MPFS also contains provisions for the continuance of Telehealth services.

End Dates by Payers for Relaxed Telehealth Visit Rules

Insurance Plan	Proposed End Date
Aetna	Until further notice
BCBS No Dakota	until end of COVID-19 emergency
BCBS So Dakota	until further notice
BCBS Oklahoma	until end of COVID-19 emergency
BCBS Federal Plan	until end of COVID-19 emergency
Cigna	12/31/2020 **
GEHA	until further notice
Humana	until end of COVID-19 emergency
Medicare	until end of COVID-19 emergency
Tricare	until end of COVID-19 emergency
UnitedHealthcare Medicare Advantage	until end of COVID-19 emergency
UnitedHealthcare	December 31, 2020 ***

-- updated 12/30/20

**** Cigna's Virtual Care Policy, effective January 1, 2021**

Cigna will reimburse virtual care services when all of the following are met:

1. Modifier 95 or GQ or GT is appended to the appropriate CPT code;
2. Services must be interactive and use both audio and video internet-based technologies
3. The customer and/or actively involved caregiver must be present on the receiving end and the service must occur in real time;
4. All technology used must be secure and meet or exceed federal and state privacy requirements;
5. A permanent record of online communications relevant to the ongoing medical care and follow-up of the customer is maintained as part of the customer's medical record as if the service were provided as an in-office visit;
6. The permanent record must include documentation which identifies the virtual service delivery method. I.e.: audio/video or telephone only;
7. All services provided are medically appropriate and necessary;
8. The E/M provided virtually must meet E/M criteria;
9. The customer's clinical condition is considered to be of low to moderate complexity;
10. Virtual care services must be provided by a health care professional who is licensed, registered, or otherwise acting within the scope of his/her licensure.

For more information, please go to:
https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/Notifications/R31_Virtual_Care.pdf

***** UnitedHealthcare's Telehealth Reimbursement Policy effective January 1, 2021**

For commercial plans, effective January 1, 2021, United Healthcare expanded its Telehealth and Telemedicine Policy as follows:

- Eligible telehealth services will only be considered for reimbursement when reported with POS 02 (Telehealth Services).
- UnitedHealthcare will consider the member's home as an originating site for eligible services.
- Various codes will be eligible for consideration under the policy including codes listed in the current policy, as well as similar types of services rendered using interactive audio and video technology.
- Certain physical, occupational and speech therapy (PT/OT/ST) telehealth services using interactive audio and video technology will be considered for reimbursement when rendered by qualified health care professionals.
- The policy addresses additional provider-member electronic communication including virtual check-ins, remote patient monitoring and E-visits (non-face-to-face, member-initiated communications with providers using online patient portals).
- Payment will align with applicable state law.

For Medicare Advantage plans, relaxed telehealth rules will continue until the end of the COVID-19 emergency. UnitedHealthcare Medicare Advantage plans will allow certain CMS-eligible telehealth services when billed for members at home. For plans with this telehealth benefit, details will be outlined in the member's Evidence of Coverage (EOC) and other plan benefit documents.

For UnitedHealthcare Community Plans, UHC will continue to follow state regulations and guidelines regarding telehealth services and reimbursement. If no state guidance is provided, UnitedHealthcare guidelines will apply, if appropriate.

For more details, please visit UnitedHealthcare's website.
https://www.uhcprovider.com/en/resource-library/news/Novel-Coronavirus-COVID-19/covid19-telehealth-services.html

More MIPS News

2020 MIPS Performance Year Data Submission Window Opens January 4, 2021

Please remember that you will need a Quality Payment Program login in order to submit your MIPS data for 2020. *Your password will need to be updated if you have not accessed your account within the last 6 months.*

Directions for creating a login are available on the Quality Payment Program website at https://qpp.cms.gov.

Extreme and Uncontrollable Circumstance Exception Application Deadline Extended

To further support clinicians during the COVID-19 public health emergency, CMS is extending the 2020 MIPS Extreme and Uncontrollable Circumstances Exception application deadline to February 1, 2021.

If you are concerned about the effect of the COVID-19 PHE on your 2020 performance data, submit an application now and be sure to cite COVID-19 as the reason for your application.

If you have an approved application, you can still receive scores for the Quality, Improvement Activities and Promoting Interoperability performance categories if you submit data. If the Cost performance category is included in your approved application, you will not be scored on cost measures even if other data are submitted.

Go to the Quality Payment Program website and sign in. Select 'Exceptions Applications' on the left-hand navigation pane then select 'Add New Exception." Complete the 'Extreme and Uncontrollable Circumstances Exception' form.

Important Dates to Remember:

- **January 4, 2021** – 2020 MIPS performance year data submission window opens.
- **February 1, 2021** – 2020 Extreme and Uncontrollable Circumstances Application period closes.
- **March 1, 2021** – Deadline for CMS to receive 2020 claims for the Quality performance category. Claims must be received by CMS within 60 days of the end of the performance period.
- **March 31, 2021** – 2020 MIPS performance year data submission window closes.

Medicare Updates

99072 Update

Following the publication of the 2021 PFS Proposed Rule, the CPT Editorial Panel approved the creation of CPT code 99072 (Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease).

After reviewing all the information submitted by stakeholders, CMS ruled that 99072 would be considered a bundled service on an interim basis. CMS agrees with stakeholders that there have been additional costs for providers as part of the PHE for COVID19; however, payment for the services as described under CPT code 99072 are always bundled into payment for other services and payment for them is subsumed by the payment for the services to which they are incident.

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