2021 Medicare Physician Fee Schedule (PFS)

Final Rule Summary for ASAM Members

On December 2, 2020, the Centers for Medicare and Medicaid Services (CMS) released the Final Rule that makes revisions to the CY 2021 payment policies under the Medicare Physician Fee Schedule (PFS) and makes other policy changes, including implementation of certain provisions of the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (the SUPPORT Act).

CMS has also published a fact sheet on the PFS final rule, available here.

Outpatient and Office E/M Visits

Last year, CMS adopted AMA CPT coding and documentation guidelines to report office and outpatient E/M visits based on either medical decision-making or physician time and reduce unnecessary documentation. These changes will be effective beginning January 1, 2021. The changes include:

- Code redefinitions that rely on time or medical decision making for selecting visit level, with performance of history and exam as medically appropriate
- Deletion of level 1 new patient code
- A new prolonged services code specific to office/outpatient E/M visits
- Increased valuation to recognize shifts in medical practice and appropriately reflect resources involved in providing these services, particularly primary care to manage chronic disease

CMS also adopted the relative value recommendations made by the AMA/Specialty Society RVS Update Committee (RUC) for the office and outpatient E/M visits, which will lead to significant payment increases for these services in 2021.

By law, significant increases in Medicare physician payment rates must be offset by across-the-board decreases. Accordingly, CMS has finalized a significant budget neutrality adjustment. The CY 2021 physician payment conversion factor is $32.41, a decrease of $3.68 (10.2%) from the CY 2020 conversion factor of $36.09.

Telehealth

CMS permanently added several services to the Medicare telehealth services list, including Group Psychotherapy (CPT code 90853).

Medicare Coverage for Opioid Use Disorder Treatment Services Furnished by Opioid Treatment Programs (OTPs)

CMS finalized its proposal to extend the definition of OUD treatment services to include opioid antagonist medications, specifically naloxone, that are approved by Food and Drug Administration under section 505 of the Federal Food, Drug, and Cosmetic Act for emergency treatment of opioid overdose, and overdose education provided in conjunction with opioid antagonist medication.

It also created a new add-on code to cover the cost of providing patients with nasal naloxone (**HCPCS code G2215**) and priced this code based upon the methodology set forth in section 1847A of the Act, except that the payment amount shall be average sales price (ASP) + 0. Since auto-injector naloxone is no longer available in the marketplace, CMS instead finalized a second new add-on code (**HCPCS code G2216**) to cover the cost of providing patients with injectable naloxone and is contractor pricing this code for CY 2021.

CMS will apply a frequency limit on the codes describing naloxone, but will allow exceptions in the case where the beneficiary overdoses and uses the supply of naloxone given to them by the OTP, to the extent that the additional supply of naloxone is medically reasonable and necessary.

Finally, CMS finalized the proposal to allow periodic assessments to be furnished via two-way interactive audio-video communication technology, as clinically appropriate, and in compliance with all applicable requirements.

For more information on Medicare billing and payment for OTP services, including covered services and payment rates, please see this CMS Fact Sheet.

Bundled Payments under the PFS for Substance Use Disorders (HCPCS codes G2086, G2087, and G2088)

In the CY 2020 PFS final rule (84 FR 62673), CMS finalized the creation of new coding and payment describing a bundled episode of care for the treatment of Opioid Use Disorder (OUD). In response to requests to expand those bundled payments to be inclusive of other SUDs, not just OUD, CMS is revising the code descriptors by replacing "opioid use disorder" with "a substance use disorder." The payment and billing rules otherwise remain unchanged. Specifically,

- These codes are not limited to any particular physician or nonphysician practitioner (NPP) specialty, but CMS recommends that practitioners furnishing SUD treatment services should consult with addiction specialists, as clinically appropriate.
- At least one psychotherapy service must be furnished in order to bill for HCPCS codes G2086 or G2087, as their payment rate incorporates the resource costs involved in furnishing psychotherapy.
- CMS recognizes that stable patients may not require monthly psychotherapy and encourages clinicians to use existing codes that describe care management services (CPT codes 99484, 99492, 99493, and 99494) and E/M services rather than the new codes for SUD service bundles for patients who do not require at least monthly psychotherapy.
- Any of the individual therapy, group therapy and counseling services included in the new HCPCS codes G2086-G2088 can be furnished via telehealth, as clinically appropriate, in order to increase access to care for beneficiaries.

The new code descriptors are:

- **HCPCS code G2086**: Office-based treatment for a substance use disorder, including development of the treatment plan, care coordination, individual therapy and group therapy and counseling; at least 70 minutes in the first calendar month.

- **HCPCS code G2087**: Office-based treatment for a substance use disorder, including care coordination, individual therapy and group therapy and counseling; at least 60 minutes in a subsequent calendar month.
- **HCPCS code G2088**: Office-based treatment for a substance use disorder, including care coordination, individual therapy and group therapy and counseling; each additional 30 minutes beyond the first 120 minutes (List separately in addition to code for primary procedure).

HCPCS Code	RVU		Conversion Factor	2021 National Payment	2020 National Payment	Percent Change
G2086	Non-Facility	11.41	32.4085	**$369.78**	$413.22	-10.51%
	Facility	8.24	32.4085	**$267.05**	$301.35	-11.38%
G2087	Non-Facility	10.12	32.4085	**$327.97**	$368.47	-10.99%
	Facility	8.03	32.4085	**$260.24**	$293.77	-11.41%
G2088	Non-Facility	1.93	32.4085	**$62.55**	$70.01	-10.66%
	Facility	0.96	32.4085	**$31.11**	$35.01	-11.13%

Initiation of Medication Assisted Treatment (MAT) in the Emergency Department (HCPCS code G2213)

In the CY 2020 PFS proposed rule (84 FR 40545), CMS sought comment on the use of medication assisted treatment (MAT) in the emergency department (ED) setting, including initiation of MAT and the potential for either referral or follow-up care. It was persuaded by the comments received that this work is not currently accounted for in the existing code set. To account for the resource costs involved with initiation of medication for the treatment of opioid use disorder in the ED and referral for follow-up care, CMS is creating one add-on G-code to be billed with E/M visit codes used in the ED setting:

- **HCPCS code G2213**: Initiation of medication for the treatment of opioid use disorder in the emergency department setting, including assessment, referral to ongoing care, and arranging access to supportive services (List separately in addition to code for primary procedure).

HCPCS Code	RVU		Conversion Factor	2021 National Payment
G2213	Non-Facility	1.98	32.4085	**$64.17**
	Facility	1.89	32.4085	**$61.25**

Electronic Prescribing of Controlled Substances

Section 2003 of the SUPPORT Act requires that, effective January 1, 2021, the prescribing of a Schedule II, III, IV, or V controlled substance under Medicare Part D be done electronically in accordance with an electronic prescription drug program, To help ensure that section 2003 of the SUPPORT Act is implemented smoothly and with minimal burden to prescribers, in the CY 2021 PFS final rule CMS finalized that prescribers be required to use the National Council for Prescription Drug Programs, (NCPDP) SCRIPT 2017071 standard for EPCS prescription transmissions, the same standard which Part D

plans are already required to support. CMS finalized the provision with an effective date of January 1, 2021 and a compliance date of January 1, 2022 to encourage prescribers to implement EPCS as soon as possible, while helping ensure that its compliance process is conducted thoughtfully. It noted that physicians who do not implement EPCS "until January 1, 2022 will still be considered compliant with the requirement."