OMFS Update for Physician and Non-Physician Practitioner Services

Explanation of Changes

(Effective March 1, 2021)

1. **Data Sources**

**CY 2021 Medicare Physician Fee Schedule Final Rule**

The Center for Medicare and Medicaid Services’ CY 2021 update to the Medicare physician fee schedule was published in the Federal Register on December 28, 2020 (85 Fed. Reg. 84472). It is entitled “Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Quality Payment Program; Coverage of Opioid Use Disorder Services Furnished by Opioid Treatment Programs; Medicare Enrollment of Opioid Treatment Programs; Electronic Prescribing for Controlled Substances for a Covered Part D Drug; Payment for Office/Outpatient Evaluation and Management Services; Hospital IQR Program; Establish New Code Categories; Medicare Diabetes Prevention Program (MDPP) Expanded Model Emergency Policy; Coding and Payment for Virtual Check-in Services Interim Final Rule Policy; Coding and Payment for Personal Protective Equipment (PPE) Interim Final Rule Policy; Regulatory Revisions in Response to the Public Health Emergency (PHE) for COVID–19; and Finalization of Certain Provisions from the March 31st, May 8th and September 2nd Interim Final Rules in Response to the PHE for COVID–19” [CMS–1734–F, CMS–1734–IFC, CMS–1744–

F, CMS–5531–F and CMS–3401–IFC]. Hereafter, the final rule will be referenced as “CY 2021 Medicare Physician Fee Schedule Final Rule, CMS-1734-F.”

The [CY 2021 Medicare Physician Fee Schedule Final Rule, CMS-1734-F, and supporting download files](https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1734-f) are available on the CMS website.

**CY 2020 Medicare Physician Fee Schedule Final Rule**

The Center for Medicare and Medicaid Services’ CY 2020 update to the Medicare physician fee schedule was published in the Federal Register on November 15, 2019 (84 Fed. Reg. 62568). It is entitled “Medicare Program; CY 2020 Revisions to Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicaid Promoting Interoperability Program Requirements for Eligible Professionals; Establishment of an Ambulance Data Collection System; Updates to the Quality Payment Program; Medicare Enrollment of Opioid Treatment Programs and Enhancements to Provider Enrollment Regulations Concerning Improper Prescribing and Patient Harm; and Amendments to Physician Self-Referral Law Advisory Opinion Regulations Final Rule; and Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule” [CMS-1715-F and IFC]. Hereafter, the final rule will be referenced as “CY 2020 Medicare Physician Fee Schedule Final Rule, CMS-1715-F.”

The [CY 2020 Medicare Physician Fee Schedule Final Rule, CMS-1715-F, and supporting download files](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices.html) are available on the CMS Physician Fee Schedule Federal Regulation web page.

**Congressional Legislation**

[Consolidated Appropriations Act, 2021 (HR 133)](https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf) Public Law 116-260.

1. **Revisions Adopted by Update Order to Conform to Relevant Medicare Changes**

**Title 8 CCR § 9789.12.11. Evaluation and Management: Coding – New Patient; Documentation.**

The regulation is amended to conform to CY 2021 Medicare changes. The 2021 Medicare Physician Fee Schedule eliminates the use of “The 1995 Documentation Guidelines for Evaluation & Management Services” and “The 1997 Documentation Guidelines for Evaluation and Management Services.”

Instead of the 1995 and 1997 guidelines, the American Medical Association *Current Procedural Terminology* guidelines on evaluation and management coding will be used in the Medicare Physician Fee Schedule. The 2020 Medicare Physician Fee Schedule Final Rule CMS 1715-F eliminated the use of the 1995 and 1997 Evaluation and Management Documentation Guidelines to be effective beginning CY 2021. CMS has substantially adopted the revised Evaluation and Management Coding and guidelines for office/outpatient services developed by the American Medical Association.

The change as proposed is described as follows in the CY 2020 Medicare Physician Fee Schedule Final Rule:

“For CY 2021, for office/outpatient E/M visits (CPT codes 99201–99215), we proposed generally to adopt the new coding, prefatory language, and interpretive guidance framework that has been issued by the AMA/CPT [citation] because we believed it would accomplish greater burden reduction than the policies we finalized for CY 2021 and would be more intuitive and consistent with the current practice of medicine. We noted that this includes deletion of CPT code 99201 (Level 1 office/outpatient visit, new patient), which the CPT Editorial Panel decided to eliminate as CPT codes 99201 and 99202 are both straightforward MDM [medical decision making] and only differentiated by history and exam elements.

Under this new framework, history and exam would no longer be used to select the level of code for office/ outpatient E/M visits. Instead, an office/ outpatient E/M visit would include a medically appropriate history and exam, when performed. The clinically outdated system for number of body systems/areas reviewed and examined under history and exam would no longer apply, and these components would only be performed when, and to the extent, medically necessary and clinically appropriate. Level 1 visits would only describe or include visits performed by clinical staff for established patients, and the concept of medical decision making would not apply to CPT code 99211.

For levels 2 through 5 office/ outpatient E/M visits, the code level reported would be decided based on either the level of MDM (as redefined in the new AMA/CPT guidance framework) or the total time personally spent by the reporting practitioner on the day of the visit (including face-to face and non-face-to-face time).” [CY 2020 Medicare Physician Fee Schedule Final Rule CMS 1715-F, 84 Federal Register 62568 at page 62847.]

CMS finalized the adoption of the revised office/outpatient visit coding structure, noting:

“We agree with the majority of commenters that time and MDM are each important measures of office/outpatient E/M visit complexity that practitioners should have the option to use to select visit level, and that history and physical exam only need to be performed and documented as medically appropriate. Therefore, we are finalizing our proposal to adopt the MDM guidelines as revised by CPT and allow the use of time or MDM to select office/outpatient E/M visit level beginning January 1, 2021.”

[CY 2020 Medicare Physician Fee Schedule Final Rule CMS 1715-F, 84 Federal Register 62568 at page 62848]

CMS diverges from the AMA coding in regard to prolonged services on the day of the office/outpatient visit. Due to concern regarding ambiguity of calculation of time under the CPT language, and potential double counting of time involved in the visit codes and the prolonged services code, CMS developed a HCPCS code G2212 to be used instead of CPT code 99417.

The CY 2021 Physician Fee Schedule Final Rule states:

“While we prefer to align with CPT coding to reduce potential confusion to practitioners, we continue to believe that CPT code 99417 as written is unclear and that allowing reporting of CPT code 99417 when the minimum required time for the level 5 visit is exceeded by at least 15 minutes would result in double counting time. It has not been our understanding that CPT intended for the midpoint time to suffice for reporting this code, and regardless, we did not previously finalize or intend to apply such a policy.

We continue to believe it is important for CMS and other stakeholders to know with certainty how much time practitioners spend furnishing office/ outpatient E/M visits, in order to assess whether resources are accurately accounted for in their valuation. This is especially true once time can be used to select visit level, with new times established for this code set. To resolve the lack of clarity, we are finalizing our proposal regarding the time that may be counted for prolonged office/outpatient E/M visits; and to resolve the potential inconsistency of our policy with CPT code 99417, we are creating a new HCPCS code G2212 to be used when billing Medicare for this service instead of CPT code 99417, starting in 2021.”

[CY 2021 Medicare Physician Fee Schedule CMS 1734-F, 85 Federal Register 84472, 84573]

The workers’ compensation Physician and Non-Physician Practitioner Fee Schedule is updated to conform to the Medicare coding changes relating to office visit codes and coding guidelines. Therefore, section 9789.12.11, subdivision (b) is amended to state that the subdivision requiring use of the 1995 and 1997 documentation guidelines is applicable to services rendered *prior to* March 1, 2021. A new subdivision (c) for services on or after March 1, 2021, is adopted to specify that the office visit evaluation and management code selection shall be in accordance with the AMA CPT coding and guidelines, except where otherwise specified in the regulations. Subparagraphs (c)(1) and (c)(2) are added to conform to Medicare’s use of the new HCPCS code G2212 instead of CPT code 99417 for prolonged services on the same day as an office visit.

**Title 8 CCR § 9789.12.12. Consultation Services Coding - Use of Visit Codes.**

The workers’ compensation physician fee schedule follows the Medicare rule that consultation services are to be billed using the CPT visit codes rather than the CPT consultation codes. Amendments are adopted to subdivision (a) in light of the fact that office visit code descriptors and guidelines have been revised, as described above. Since selection of the level of code is based upon revised factors, the language of the regulation is modified to accommodate the new descriptors. In addition, the CPT code range of “99201 to 99215” has been changed to “99202 to 99215” in light of the fact that the AMA has deleted code 99201 from the CPT and is not used by Medicare as of January 1, 2021.

**Update Table**

**Title 8 CCR §9789.19:** A new subdivision (h) is added, adopting updates for services rendered on or after March 1, 2021, to conform to Medicare changes, as follows:

| **Document/Data** | **Services Rendered On or After March 1, 2021 & Mid-year Updates** |
| --- | --- |
| Adjustment Factors- Services Other than Anesthesia | Updated to include the relevant 2021 Medicare adjustment factors:2021 RVU budget neutrality adjustment factor: -6.81% (.9319) (Adjusted by CMS after publication of CY 2021 Medicare Physician Fee Schedule Final Rule, CMS-1734-F due to provisions of Consolidated Appropriations Act, 2021 (HR 133))2021 Annual increase in the MEI: 1.4% (1.014) [CMS’ [Actual Regulation Market Basket Updates (ZIP)](https://www.cms.gov/files/zip/actual-regulation-market-basket-updates.zip)]Consolidated Appropriations Act, 2021, increase of 3.75% (1.0375)[See detailed explanation set forth below this table.] |
| Adjustment Factors - Anesthesia | Updated to include the relevant 2021 Medicare adjustment factors:2021 RVU budget neutrality adjustment factor: -6.81% (.9319) (Recalculated by CMS after publication of CY 2021 Medicare Physician Fee Schedule Final Rule, CMS-1734-F due to provisions of Consolidated Appropriations Act, 2021 (HR 133))2021 Anesthesia practice expense and malpractice adjustment factor: 0.44 percent (1.0044) (Recalculated by CMS after publication of CY 2021 Medicare Physician Fee Schedule Final Rule, CMS-1734-F due to provisions of Consolidated Appropriations Act, 2021 (HR 133))2021 Annual increase in the MEI: 1.4% (1.014) [CMS’ [Actual Regulation Market Basket Updates (ZIP)](https://www.cms.gov/files/zip/actual-regulation-market-basket-updates.zip)]Consolidated Appropriations Act, 2021, increase of 3.75% (1.0375)[See detailed explanation set forth below this table.] |
| Anesthesia Base Units by CPT Code | The anesthesia base units are unchanged for 2021, and are found in the excel file: [cms1676f\_cy\_2018\_anesthesia\_base\_units.xlsx](https://www.cms.gov/Center/Provider-Type/Anesthesiologists-Center.html). |
| California-Specific Codes | The maximum fee for each of these codes has been updated by the MEI 1.4% increase (1.014) pursuant to section 9789.12.14. |
| CCI Edits: Medically Unlikely Edits | Updated for services rendered on or after March 1, 2021, use: “Practitioner Services MUE Table – Effective 01-01-2021 Replacement-Posted December 14, 2020 (ZIP)”, excluding all codes listed with Practitioner Services MUE Value of “0” (zero).” DWC has created and posted an excerpt of the file excluding the “zero” value codes for the convenience of the public. |
| CCI Edits: National Correct Coding Initiative Policy Manual for Medicare Services | Updated to the CMS’ 2021 annual manual. |
| CCI Edits: Practitioner Procedure to Procedure (PTP) Edits | Updated to “Practitioner PTP Edits, v270r0, Effective January 1, 2021, (posted 12/01/2020)”. |
| CMS’ Medicare National Physician Fee Schedule Relative Value File [Zip] | Updated to the CMS’ 2021 RVU21A (Updated 01/05/2021). |
| Conversion Factors adjusted for MEI and Relative Value Scale adjustment factors | Updated the conversion factors in accordance with Labor Code §5307.1, subdivision (g)(1)(A) and subdivision (c) of title 8, California Code of Regulations, § 9789.12.5 and in accordance with relevant provisions of the Consolidated Appropriations Act adjustment.The 2021 Adjusted Conversion Factor for services other than Anesthesia is the Conversion Factor used to determine the maximum fees.The Conversion Factor for anesthesia is further adjusted to calculate the 2021 GPCI-Adjusted Anesthesia Conversion Factors set forth in Table A. These GPCI-adjusted conversion factors are used to determine the maximum fees for services rendered in the specified localities.[See detailed explanation set forth below this table.] |
| Current Procedural Terminology (CPT®) | Updated to CPT® 2021. |
| Current Procedural TerminologyCPT codes that shall not be used | Revised to add the CPT code 99417 to the list of CPT codes that shall not be used. CPT code 99417 is Status Code “I” indicating that Medicare uses a different code. Adopt use of the HCPCS Code G2212 and descriptor which is adopted by Medicare for use instead of CPT 99417 (see sections 9789.12.3(c)(4) and 9789.12.11(c).)  |
| Diagnostic Cardiovascular Procedure CPT codes subject to the MPPR | Updated to 2021. |
| Diagnostic Imaging Family Indicator Description | Unchanged, updated reference to 2021. |
| Diagnostic Imaging Family Procedures Subject to the MPPR | Updated to 2021. |
| Diagnostic Imaging Multiple Procedures Subject to the MPPR | Updated to 2021. |
| DWC Pharmaceutical Fee Schedule | Sets forth reference to DWC pharmaceutical fee schedule web page, which is unchanged from 2020. |
| Geographic Practice Cost Index (GPCI) by locality (Other than anesthesia services) | Adopted and incorporated by reference specified columns of files from the 2021 CMS’ Medicare National Physician Fee Schedule Relative Value File RVU21A (Updated 01/05/2021)(ZIP):* GPCI2021 (Column C (“Locality Number”), column D (“Locality Name”), column E (“2021 PW GPCI”), column F (“2021 PE GPCI”), and column G (“2021 MP GPCI”) for the State of California (“CA”))

[Based on Addendum E to CY 2021 Medicare Physician Fee Schedule Final Rule, CMS-1734-F which can be accessed in [CY 2021 PFS Final Rule Addenda (Updated 12/29/2020) (ZIP)](https://www.cms.gov/files/zip/cy-2021-pfs-final-rule-addenda-updated-12292020.zip) on CMS website]* 21LOCCO – Column B (“Locality Number”), column C (“State”), column D (“Fee Schedule Area”), and column E (“Counties”) for the State of California (“CA”)
 |
| Geographic Practice Cost Index (GPCIs) by locality and anesthesia shares (Anesthesia) | The Medicare 2021 locality GPCIs and Medicare 2021 Anesthesia Shares are utilized to update the workers’ compensation Anesthesia Conversion Factor, as set forth on Table A, title 8 CCR, section 9789.19.1.Medicare data utilized is as follows.GPCIs:[RVU21A](https://www.cms.gov/files/zip/rvu21a-updated-01052021.zip) (Updated 01/05/2021) (ZIP) GPCI2021 – Column C (“Locality Number”), column D (“Locality Name”), column E (“2021 PW GPCI (without 1.0 Floor)”), column F (“2021 PE GPCI”), and column G (“2021 MP GPCI”) for the State of CaliforniaAnesthesia Shares:[2021 Anesthesia Conversion Factors [ZIP]](https://www.cms.gov/files/zip/2021-anesthesia-conversion-factors.zip) (Updated 12/29/2020)* Anesthesia Shares [excel sheet: Anesthesia Shares]

Locality for anesthesia services determined by Medicare county to locality index.[RVU21A](https://www.cms.gov/files/zip/rvu21a-updated-01052021.zip) (County to locality index)* 21LOCCO – Column B (“Locality Number”), column C (“State”), column D (“Fee Schedule Area”), and column E (“Counties”) for the State of California (“CA”)
 |
| Geographic Practice Cost Index (GPCI) locality mappingZip Code files mapping zip codes to GPCI locality (for “other than anesthesia services” and anesthesia services) | Updated to the 2021 files for services rendered on or after March 1, 2021:Zip Code to Carrier Locality File – Revised 11/19/2019 [ZIP], Column A (“STATE”), column B (“ZIP CODE”), and column D (“LOCALITY”) for the State of California (“CA”)Zip Codes requiring 4 extension – Revised 11/19/2019 [ZIP], for the State of California (“CA”)The current [CMS Zip Code to Carrier Locality files](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/FeeScheduleGenInfo/index) can be accessed on the CMS website. |
| Geographic Health Professional Shortage Area zip code data files | Updated to 2021 files for the Primary Care Geographic HPSA and the Mental Health Geographic HPSA. |
| Health Resources and Services Administration: Geographic HPSA shortage area query(By State & County) | Unchanged from 2020. Sets forth reference to the HRSA Geographic HPSA shortage area web page query by state/county. |
| Health Resources and Services Administration: Geographic HPSA shortage area query(By Address) | Unchanged from 2020. Sets forth reference to the HRSA Geographic HPSA shortage web page query by address. |
| Incident To Codes | Updated to 2021. |
| Medi-Cal Rates – DHCS | Updated for services rendered on or after March 1, 2021, use: Medi-Cal Rates file – Updated 2/15/2021. [The 2/15/2021 Medi-Cal rates file will be available on approximately February 16, 2021.] The Medi-Cal rates file will be updated monthly by Administrative Director’s posting order. Medi-Cal rates are updated as of the 15th of each month, posted to the Medi-Cal website on the 16th of each month, and posted to the DWC website as soon as feasible. |
| Ophthalmology Procedure CPT codes subject to the MPPR | Updated to 2021. |
| Physical Therapy Multiple Procedure Payment Reduction: “Always Therapy” Codes; and Acupuncture and Chiropractic Codes | Updated to 2021 Medicare list of “Always Therapy Codes”. In addition, retain the acupuncture codes and chiropractic manipulation codes, which are unchanged from 2020. |
| Physician Time | Updated to 2021. |
| Splints and Casting Supplies | Sets forth reference to the Durable Medical Equipment, Prosthetics, Orthotics, Supplies fee schedule applicable to the date of service; reference is unchanged from 2020. |
| Telehealth – Services Accessible Through Telehealth (using audio and video telecommunication method and audio only telecommunication method) During the COVID-19 Public Health Emergency | Updated to the Medicare Telehealth List updated 12/21/2020. |

**Adjustment Factors – Updating the Conversion Factors**

**Conversion Factor for Services Other than Anesthesia**

The 2021 conversion factor for services other than anesthesia is updated pursuant to Labor Code section 5307.1, subdivision (g)(1)(A) and title 8, CCR, section 9789.12.5, subdivision (c) and to conform to relevant changes in the Medicare Physician Fee Schedule payment system made by the [Consolidated Appropriations Act, 2021 (HR 133)](https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf), Division N - Additional Coronavirus Response and Relief, Title I - Healthcare, Section 101 Supporting Physicians and Other Professionals in Adjusting to Medicare Payment Changes During 2021.

Labor Code section 5307.1, subdivision (g)(1)(A) states in part as follows:

(g) (1) (A) Notwithstanding any other law, the official medical fee schedule *shall be adjusted to conform to any relevant changes in the Medicare* and Medi-Cal payment systems no later than 60 days after the effective date of those changes, subject to the following provisions:

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(iii) The annual adjustment factor for physician services shall be based on the product of one plus the percentage change in the *Medicare Economic Index* and any *relative value scale adjustment factor*. [Emphasis added.]

Title 8, CCR, section 9789.12.5, subdivision (c) states:

“(c) For calendar year 2018, and annually thereafter, the Anesthesia conversion factor and the Other Services conversion factor in effect in the prior calendar year shall be updated by the Medicare Economic Index inflation rate and by the Relative Value Scale Adjustment Factor, if any.”

The 2021 annual increase in the Medicare Economic Index (MEI) is 1.4% (1.014). (CMS’ “[Actual Regulation Market Basket Updates (ZIP)](https://www.cms.gov/files/zip/actual-regulation-market-basket-updates.zip).”) The MEI is an input price index that accounts for annual changes in the various resources involved in providing physician services.

The 2021 Relative Value Scale (RVS) adjustment factor for all services other than anesthesia for 2021 is the Medicare 2021 RVU budget neutrality adjustment -6.81% (.9319). The CY 2021 Medicare Physician Fee Schedule Final Rule, CMS-1734-F, Table 104 listed the budget neutrality adjustment as -10.20 % (0.8980). CMS recalculated the budget neutrality adjustment in light of the Consolidated Appropriations Act, 2021, to derive the revised budget neutrality adjustment of -6.81% (.9319). The Consolidated Appropriations Act, 2021, delayed payment for new HCPCS complexity add-on code G2211 from 2021 to 2024. This led CMS to recalculate the budget neutrality adjustment initially set forth in the Final Rule.

The “Statutory Update Factor” of 0.00 percent in Table 104 of CY 2021 Medicare Physician Fee Schedule Final Rule, CMS-1734-F is not applicable because Labor Code §5307.1(g)(1)(A)(iii) specifies that the physician fee schedule annual updates are to be based upon the Medicare Economic Index and any relative value scale adjustment factor, and the factor is not otherwise relevant.

The Consolidated Appropriations Act, 2021, change to the Medicare Physician Fee Schedule set forth in Division N, Title I, Section 101, (a) [page 768] amends 42 USC 1395w-4 by adding a new subdivision (t) that includes a 3.75% increase in the calculation of payment amounts for calendar year 2021 only. The Act specifies that the 3.75% increase is exempt from the budget neutrality calculation. The increase adopted by the Consolidated Appropriations Act is a relevant Medicare provision and is applied in calculating the workers’ compensation conversion factor.

The 2021 CF for Services Other than Anesthesia is calculated as follows:

$46.7879 (2020 CF) \* 1.014 (MEI) \* 0.9319 (RVU Budget Neutrality Adjustment revised by CMS after Final Rule) \* 1.0375 (Consolidated Appropriations Act, 2021 increase) = $45.8700.

**Conversion Factor for Anesthesia Services**

The 2021 conversion factor for anesthesia services (before Geographic Practice Cost Index adjustment) is updated pursuant to Labor Code section 5307.1, subdivision (g)(1)(A) and title 8, CCR, section 9789.12.5, subdivision (c) and to conform to relevant changes in the Medicare Physician Fee Schedule payment system made by the [Consolidated Appropriations Act, 2021 (HR 133)](https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf), Division N - Additional Coronavirus Response and Relief, Title I - Healthcare, Section 101 Supporting Physicians and Other Professionals in Adjusting to Medicare Payment Changes During 2021.

Labor Code section 5307.1, subdivision (g)(1)(A) states in part as follows:

(g) (1) (A) Notwithstanding any other law, the official medical fee schedule *shall be adjusted to conform to any relevant changes in the Medicare* and Medi-Cal payment systems no later than 60 days after the effective date of those changes, subject to the following provisions:

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(iii) The annual adjustment factor for physician services shall be based on the product of one plus the percentage change in the *Medicare Economic Index* and any *relative value scale adjustment factor*. [Emphasis added.]

Title 8, CCR, section 9789.12.5, subdivision (c) states:

“(c) For calendar year 2018, and annually thereafter, the Anesthesia conversion factor and the Other Services conversion factor in effect in the prior calendar year shall be updated by the Medicare Economic Index inflation rate and by the Relative Value Scale Adjustment Factor, if any.”

The 2021 annual increase in the Medicare Economic Index (MEI) is 1.4% (1.014). (CMS’ “[Actual Regulation Market Basket Updates (ZIP)](https://www.cms.gov/files/zip/actual-regulation-market-basket-updates.zip).”) The MEI is an input price index that accounts for annual changes in the various resources involved in providing physician services.

The 2021 Relative Value Scale (RVS) adjustment factors for anesthesia services for 2021 are the Medicare 2021 RVU budget neutrality adjustment -6.81% (.9319) and the 2021 Anesthesia Fee Schedule Practice Expense and Malpractice Expense Adjustment 0.44% (1.0044). The CY 2021 Medicare Physician Fee Schedule Final Rule, CMS-1734-F, Table 105 listed the budget neutrality adjustment as -10.20 % (0.8980). CMS recalculated the budget neutrality adjustment in light of the Consolidated Appropriations Act, 2021, to derive the revised budget neutrality adjustment of -6.81% (.9319). The Consolidated Appropriations Act, 2021, delayed payment for new HCPCS complexity add-on code G2211 from 2021 to 2024. This led CMS to recalculate the budget neutrality adjustment initially set forth in the Final Rule. In addition, the anesthesia Practice Expense and Malpractice Expense Adjustment set forth in Table 105 of the Final Rule was revised by CMS from 0.59 (1.0059) to 0.44 (1.0044) through further revisions in light of the Consolidated Appropriations Act, 2021.

The “Statutory Update Factor” of 0.00 percent in Table 105 of CY 2021 Medicare Physician Fee Schedule Final Rule, CMS-1734-F is not applicable because Labor Code §5307.1(g)(1)(A)(iii) specifies that the physician fee schedule annual updates are to be based upon the Medicare Economic Index and any relative value scale adjustment factor and the factor is not otherwise relevant.

The Consolidated Appropriations Act, 2021, change to the Medicare Physician Fee Schedule set forth in Division N, Title I, Section 101, (a) [page 768] amends 42 USC 1395w-4 by adding a new subdivision (t) that includes a 3.75% increase in the calculation of payment amounts for calendar year 2021 only. The Act specifies that the 3.75% increase is exempt from the budget neutrality calculation. The increase adopted by the Consolidated Appropriations Act is a relevant Medicare provision and is applied in calculating the workers’ compensation anesthesia conversion factor.

The 2021 CF for Anesthesia Services (before Geographic Practice Cost Index adjustment) is calculated as follows:

$28.1215 (2020 CF) \* 1.014 (MEI) \* 0.9319 (RVU Budget Neutrality Adjustment) \* 1.0044 (Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment) \* 1.0375 (Consolidated Appropriations Act, 2021 increase) = $27.6911.

**GPCI-Adjusted Conversion Factors for Anesthesia Services – Section 9789.19.1 Table A for services on or after March 1, 2021**

For anesthesia services the GPCI adjustments are incorporated into the anesthesia conversion factors. Table A adopted pursuant to section 9789.19.1 contains the anesthesia conversion factors adjusted by Medicare locality GPCIs and anesthesia shares for anesthesia services rendered on or after March 1, 2021. The workers' compensation 2021 Anesthesia Conversion Factor is $27.6911, which has been adjusted for Medicare Economic Index inflation rate, Relative Value Scale Adjustment factors (RVU Budget Neutrality Adjustment and Anesthesia Fee Schedule Practice Expense and Malpractice Adjustment), and 3.75% increase pursuant to Consolidated Appropriations Act, 2021. The 2021 Medicare Anesthesia Shares are applied to the Work GPCI, Practice Expense GPCI, and Malpractice GPCI to derive the GPCI-Adjusted Anesthesia Conversion Factors by locality. The formula is as follows:

[(Work GPCI by locality\*Anesthesia Work Share) + (Practice Expense GPCI by locality\*Anesthesia Practice Expense Share) + (Malpractice GPCI by locality\*Anesthesia Malpractice Share)] \* Anesthesia Conversion Factor].

The anesthesia shares are obtained from the Medicare anesthesia excel document “CY 2021 locality adjusted CF 28DEC20 workfloor” within [2021 Anesthesia Conversion Factors [ZIP]](https://www.cms.gov/files/zip/2021-anesthesia-conversion-factors.zip) (Updated 12/29/2020) adopted by the Medicare Physician Fee Schedule Final Rule: CMS-1734-F and adjusted in light of the Consolidated Appropriations Act, 2021. The 2021 Work GPCI, 2021 Practice Expense GPCI, 2021 Malpractice GPCI are set forth in the RVU21A zip file in the excel document “GPCI2021” and are also contained in the excel document “CY2021 locality adjusted CF 28DEC20 workfloor”.

The anesthesia shares for 2021 are as follows.

| **Work** | **Practice Expense** | **Malpractice Expense** |
| --- | --- | --- |
| 0.782 | 0.157 | 0.061 |