

CY 2022 Proposed Rule Summary

Medicare Physician Fee Schedule (MPFS)

On July 13, 2021, the Centers for Medicare and Medicaid Services (CMS) issued the proposed rule for the Medicare Physician Fee Schedule (MPFS) for CY 2022.

The CY 2022 proposed rule is 1747 pages in length and located in its entirety at the following link: <https://www.federalregister.gov/public-inspection/2021-14973/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part>. The format of the following information is intended to serve as a summary to the proposed changes and readers are encouraged to view the document in its entirety for further details.

Highlights

- CMS is proposing a budget neutral adjustment to conversion factor (CF) of -0.14 percent. Applying this to the conversion factor of \$33.6319, minus the 3.75 percent increase outlined as part of the Consolidated Appropriation Act of 2021 which had changed it to \$34.8931, the proposed CY 2022 CF is \$33.5848.
- The decrease in CF does result in decrease in many specialties and their proposed impact; however, CMS has also applied additional decreases to many of the Practice Expense (PE) values which reflect a deeper cut to specialties such as interventional radiology, radiation oncology, vascular surgery, and oral/maxillofacial surgery. Most of the resulting cuts for the impacted specialties is due to labor pricing transition values.
 - Estimated impacts for select specialties are as follows:
 - Interventional Radiology -9%
 - Radiology -2%
 - Interventional Pain Management 1%
- Labor pricing update by CMS is proposed to be coordinated with the final year of the 4-year supply and equipment updates due to stakeholder feedback and requests. Clinical labor rates were last updated in CY 2002 and CMS is proposing to update the values for CY 2022 using CY 2019 survey data. The result is that specialties (i.e., interventional radiology) that have lower direct costs associated to clinical labor are seeing decreases in payment for their services. These adjustments are due to the budget neutral application of increases and decreases in payments by Medicare. Table 5 of the proposed rules are included later in this summary.
 - CMS estimates the effect of labor pricing update alone on specialty impacts is as follows:
 - Interventional Radiology -5%
 - Radiology -1%
 - Interventional Pain Management -1%
- CMS anticipates the Radiation Oncology (RO) Model will be an Advanced APM for the 2022 Quality Payment (QP) Performance Period. No other information was provided about the RO Model.

- CMS is seeking comments and feedback regarding how to better understand the resource costs for services utilizing software algorithms and AI technology. CMS has submitted several questions for which they are seeking feedback from stakeholders.
- CMS is proposing several valuations to codes and code sets for CY 2022.
 - Trabecular bone score (77X01-77X04)
 - Needle Biopsy of Lymph Nodes (38505)
 - Arthrodesis Compression (630XX and 630X1)
 - Destruction by Neurolytic Agent (64633, 64634, 64635, and 64636)
 - Destruction of Intraosseous Basivertebral Nerve (CPT codes 646X0 and 646X1)
 - Cholangiography and/or Pancreatography X-Rays at Surgery Add-On (CPT code 74301)
- CMS received several requests to add various services permanently to the telehealth list of approved services. CMS clarified services which will be added or extended and those services which will be removed from the telehealth list as soon as the public health emergency (PHE) ends.
- CMS is proposing to permanently adopt coding and payment for HCPCS code G2252, one of the communication-based services.
- CMS is seeking comments on the impact of infectious disease on codes and ratesetting, specifically the impact and types of resource costs that may not be fully reflected in payment rates for existing services or could be accounted for in establishing new payment rates.
- CMS addressed changes to evaluation and management (E/M) visits which began in 2021 and specially addressed:
 - Split (or Shared) Visits
 - New and Established Patients, and Initial and Subsequent Visits
 - Payment for the Services of Teaching Physicians
- CMS has proposed to allow for Physician Assistants (PAs) to bill for services directly to Medicare and the reimbursement for those services to be paid directly to the PA, similar to Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) currently.
- CMS is proposing to delay the penalty payment phase of the Appropriate Use Criteria (AUC) program until January 1, 2023, or the January 1 that follows the declared end of the PHE for COVID-19. This will allow for CMS to develop the appropriate claims processing system edits and are seeking comments on how best to establish this.
- CMS is proposing to remove National Coverage Determination (NCD) 220.6, Positron Emission Tomography (PET) Scans to allow the Medicare Administrative Contractor (MAC) make the decisions of coverage per their beneficiaries.
- Comments for CMS-1751-P must be submitted to CMS by 5 pm ET on September 13, 2021.

Payment Rates

CY 2022 CMS is reversing the 3.75 percent increase outlined as part of the Consolidated Appropriations Act of 2021, which reversed the 10.2 percent cut finalized to the conversion factor (CF) for CY 2022. Removing this

and utilizing a CF of 33.6319, CMS applied a budget neutrality factor of -0.14 percent. This results in a proposed CF of \$33.5848.

Table 121 from the proposed ruling outlines the factors impacting the conversion factor.

TABLE 121: Calculation of the CY 2022 PFS Conversion Factor

CY 2021 Conversion Factor		34.8931
Conversion Factor without CY 2021 Consolidated Appropriations Act Provision		33.6319
Statutory Update Factor	0.00 percent (1.0000)	
CY 2022 RVU Budget Neutrality Adjustment	-0.14 percent (0.9986)	
CY 2022 Conversion Factor		33.5848

The following table outlines the combined impact per specialty including Interventional Pain Management, Interventional Radiology, and Radiology regarding RVU changes for CY 2022.

TABLE 123: CY 2022 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact**
Interventional Pain Management	\$900	0%	1%	0%	1%
Interventional Radiology	\$480	0%	-9%	0%	-9%
Radiology	\$4,397	0%	-2%	0%	-2%

The decrease in CF does result in decrease in many specialties and their proposed impact; however, CMS has also applied additional decreases to many of the Practice Expense (PE) values which reflect a deeper cut to specialties such as interventional radiology, radiation oncology, vascular surgery, and oral/maxillofacial surgery.

The relative value unit (RVU) cuts specific to the PE values are due to the adjustment of labor values and the final year of the 4-year supply and equipment updates. According to CMS there was stakeholder requests for updated labor values to correspond with the updated supply and equipment values.

Clinical labor rates were last updated in CY 2002 and CMS is proposing to update the values for CY 2022 using CY 2019 survey data from the Bureau of Labor and Statistics (BLS) and other supplementary data when BLS data is not available. Selected labor value changes from Table 5 of the proposed rules are included below. It should be noted, an increase in labor values is indicated for all of the labor types reviewed by CMS. Because the values are maintained in budget neutral manner, increases for one specialty or one code (or code set) is possible because it was taken or adjusted from another specialty or code (or code set).

Specifically, some specialties, (i.e., family practice) the labor has a higher-than-average share of the direct costs. While for other specialties (i.e., interventional radiology) the labor has a lower-than-average share of the direct costs. Specialties with the higher share of labor costs are proposed to increased payments for their services whereas specialties that have lower direct costs associated to clinical labor are seeing decreases in payment for their services.

TABLE 5: Proposed Clinical Labor Pricing Update

Labor Code	Labor Description	Source	Current Rate Per Minute	Updated Rate Per Minute	% Change
L041A	Angio Technician*	BLS 29-9000	0.41	0.62	51%
L041B	Radiologic Technologist	BLS 29-2034	0.41	0.69	68%
L041C	Second Radiologic Technologist for Vertebroplasty	BLS 29-2034	0.41	0.69	68%
L043A	Mammography Technologist*	BLS 29-1126	0.43	0.70	63%
L046A	CT Technologist*	BLS 29-2035	0.46	0.81	76%
L047A	MRI Technologist	BLS 29-2035	0.47	0.81	72%
L050B	Diagnostic Medical Sonographer	BLS 29-2032	0.50	0.83	66%
L051B	RN/Diagnostic Medical Sonographer	L051A, BLS 29-2032	0.51	0.84	65%
L054A	Vascular Technologist*	BLS 19-1040	0.54	1.07	98%
L152A	Medical Physicist	BLS 19-2012 (75th percentile)	1.52	1.80	18%

CMS isolated the anticipated impacts the labor value changes would have on the various specialties and the payment for their services. CMS indicated when updates to payment methodology result in significant shifts in payments, they do consider the possibility and impact of phasing-in the changes. Typically, this is done over a 4-year transition. This is the concept applied when the supply and equipment value changes were implemented in CY 2019 and spread over a 4-year timeline. CMS is concerned a phased in transition would result in the need to use outdated clinical labor pricing for the time the transition is taking place since each year would use partial new values and older values to calculate payment.

Table 6 from the proposed rule reflects the anticipated values of the clinical labor pricing on the specialties alone, this does not account for any other impacts outlined within the proposed rule. Due the application of budget neutrality some of the more specialized healthcare specialties are proposed to see larger cuts to codes than non-specialized healthcare specialties. This could result in greater than the proposed -9 percent total impact to some codes or code sets as it is not equal across every code, it will depend on the weights and values calculated into each code or code set.

TABLE 6: Anticipated Clinical Labor Pricing Effect on Specialty Impacts

Specialty	Allowed Charges (mil)	New CL Pricing Change
Interventional Pain Mgmt	\$936	-1%
Radiology	\$5,275	-1%
Vascular Surgery	\$1,293	-4%
Interventional Radiology	\$499	-5%
Diagnostic Testing Facility	\$748	-6%

Proposed Valuation of Specific Codes for CY 2022

CMS acknowledge that technology is quickly advancing for many types of services available to their beneficiaries. They also acknowledged some of this advancement could have been accelerated by COVID-19 and the resulting public health emergency (PHE). Some of the services are expected to bridge the gaps or disparities in care while also substituting and/or augmenting necessary physician work. CMS specifically addressed the emergence of services utilizing software algorithms and AI technology and how to best value the physician work and practice expense.

CMS is asking stakeholders to consider the following questions:

- To what extent are services involving innovative technologies such as software algorithms and/or AI substitutes and/or supplements for physician work?
- To what extent do these services involving innovative technology inform, augment, or replace physician work?
 - For example, CPT code 77X01 is a service in which the trabecular bone score software may be supplementing physician work to predict and detect fracture risk.
- How has innovative technology such as software algorithms and/or AI affected physician work time and intensity of furnishing services involving the use of such technology to Medicare beneficiaries?
 - For example, if a new software algorithm or AI technology for a diagnostic test results in a reduction in the amount of time that a practitioner spends reviewing and interpreting the results of a diagnostic test that previously did not involve such software algorithm or AI technology, and if the software algorithm or AI could be considered in part a substitute for at least some physician work, it may follow that the intensity of the service decreases. It is also possible that a software algorithm for a diagnostic test that is supplementing other tests to establish a diagnosis or treatment pathway for a particular condition could result in an increase in the amount of time that a practitioner spends explaining the test to a patient and then reviewing the results.
- How is innovative technology such as software algorithms and/or AI changing cost structures in the physician office setting?
 - As discussed previously, the PPIIS data that underlie the PE methodology were last collected in 2007 and 2008, which was prior to the widespread adoption of electronic health records and services that involve care management, non-face-to-face and/or asynchronous remote care; the

need to use electronic clinical quality measure data to support quality improvement, disparity identification and resolution, and value based payment; and the emergence of software algorithms and/or AI and other technologies that use data to inform, augment, or replace physician work in the delivery of health care.

- Do costs for innovative technology such as software algorithms and/or AI to furnish services to patients involve a one-time investment and/or recurring costs?
- How should CMS consider costs for software algorithms and/or AI that use patient data that were previously collected as part of another service?
- As technology adoption grows, do these costs decrease over time?
- How is innovative technology affecting beneficiary access to Medicare-covered services?
- How are services involving software algorithms and/or AI being furnished to Medicare beneficiaries and what is important for CMS to understand as it considers how to accurately pay for services involving software algorithms and/or AI?
 - For example, it is possible that services that involve software algorithms and/or AI may allow a practitioner to more efficiently furnish care to more Medicare beneficiaries, potentially increasing access to care.
- Additionally, to what extent have services that involve innovative technology such as software algorithms and/or AI affected access to Medicare-covered services in rural and/or underserved areas, or for beneficiaries that may face barriers (homelessness, lack of access to transportation, lower levels of health literacy, lower rates of internet access, mental illness, having a high number of chronic conditions/frailty, etc.) in obtaining health care?
- Compared to other services paid under the PFS, are services that are driven by or supported by innovative technology such as software algorithms and/or AI at greater risk of overutilization or more subject to fraud, waste, and abuse?
- As we are considering appropriate payment for services enabled by new technologies, there are considerations for program integrity. For example, section 218(b) of the PAMA required that we establish an Appropriate Use Criteria Program to promote appropriate use of advanced diagnostic imaging services provided to Medicare beneficiaries.
- To what extent do services involving innovative technology require mechanisms such as appropriate use criteria to guard against overutilization, fraud, waste, or abuse?
- Compared to other services paid under the PFS, are services driven by or supported by innovative technology such as software algorithms and/or AI associated with improvements in the quality of care or improvements in health equity?
 - For example, increased access to services to detect diabetic retinopathy such as the service described by CPT code 92229 could eventually lead to fewer beneficiaries losing their vision. Because CPT code 92229 can be furnished in a primary care practice's office and may not require the specialized services of an ophthalmologist, more beneficiaries could have access to a test, including those who live in areas with fewer ophthalmologists.
- Additionally, taking into consideration that a software algorithm and/or AI may introduce bias into clinical decision making that could influence outcomes for racial and ethnic minorities and people who

are socioeconomically disadvantaged, are there guardrails, such as removing the source of bias in a software algorithm and/or AI, that Medicare should require as part of considering payment amounts for services enabled by software algorithm and/or AI?

- Our proposals to use crosswalks to set values for codes describing diabetic retinopathy and trabecular bone score would allow us to account for overall resource costs involved in furnishing the services. The possible crosswalks for FFRCT may also account for overall resource costs involved in furnishing the service. We also believe it is important to accurately account for resource costs for innovative and emerging technologies such as ongoing service-specific software costs and, as explained above, such costs are not well accounted for in the PE methodology. We continue to be interested in potentially refining the PE methodology and updating the underlying data, including the PPIS data that are the data source that underpins the indirect PE allocation. How might CMS consider updating such data to reflect ongoing advances in technology so that we could establish appropriate relative values without resorting to crosswalks?
- The RAND Corporation laid out a number of issues for CMS to consider in two reports. We refer readers to RAND's first phase of research, available at https://www.rand.org/pubs/research_reports/RR2166.html, and RAND's second phase of research, available at https://www.rand.org/pubs/research_reports/RR3248.html.

Specific Codes and Code Set Valuations

Trabecular bone score (77X01-77X04)

The trabecular bone score codes are new for CY 2022. Since these codes meet the definition of “imaging services” CMS is proposing to include them on the list of codes where the Outpatient Prospective Payment System (OPPS) cap applies. This would limit the technical amount of the imaging service to the amount for the technical service under the OPPS minus the geographic adjustment for the hospital but with the geographic adjustment under MPFS applied instead.

The definitions for the to be fully released codes are as follows:

- 77X01 (*Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual Xray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk*)
- 77X02 (*Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere*)
- 77X03 (*Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only*)
- 77X04 (*Trabecular bone score (TBS), structural condition of the bone microarchitecture; using dual X-ray absorptiometry (DXA) or other imaging data on gray-scale variogram, calculation, with interpretation and report on fracture risk interpretation and report on fracture risk only, by other qualified health care professional*)

CPT® codes 77X01 and 77X03 include new TBS iNight Software supply input. There is a licensing fee associated with the software, typically this is valued as part of the indirect PE. Stakeholder feedback has routinely questioned this policy, specifically for those technologies that rely on software and licensing fees for utilization which can add costs. CMS is proposing to use CPT® 71101 (*Radiologic examination, ribs, unilateral; including posteroanterior chest, minimum of 3 views*) as a base for establishing the proposed Work values. CMS is seeking comments on the values as well as the process related to licensing fee for software valuation.

Needle Biopsy of Lymph Nodes (38505)

CPT® code 38505 (*Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)*) was identified through the screening process with claims submissions over 30,000. Based on changes with the service which include larger tissue samples, CMS is proposing the RUC (Relative Value Update Committee) recommendations for Work and PE RVS.

Arthrodesis Compression (630XX and 630X1)

The arthrodesis compression codes are new for CY 2022. The codes 630XX (*Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure)*) and 630X1 (*Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure)*) were recommended by the RUC with what CMS considered to be high Work RVUs for add-on codes when compared to other similar services. Due to this CMS is not proposing the RUC recommended values (5.55 and 4.44 respectively) instead they are proposing Work RVU of 3.08 for CPT® code 630XX and a Work RVU of 2.31 for CPT® code 630X1.

Destruction by Neurolytic Agent (64633, 64634, 64635, and 64636)

Issues with the valuation of the deconstruction by neurolytic agent date back to September 2014 when the Relativity Assessment Workgroup (RAW) identified a work neutrality issue related to how they were originally valued. In May 2015 the CPT® Editorial Panel updated parenthetical notes for the five codes which describe paravertebral facet joint nerve destruction; clarifying these codes are billed per joint not per nerve. Because of the original issues with valuation and the significant growth of the use of these codes, they were recommended for review.

CMS is not proposing the RUC recommended Work values as they believe they do not accurately value the decrease in physician work; however, CMS is proposing the recommended direct PE inputs. Instead, CMS is proposing Work RVUs of 3.31 for code 64633 and 3.32 for code 64635.

Destruction of Intraosseous Basivertebral Nerve (CPT codes 646X0 and 646X1)

The destruction of intraosseous basivertebral nerve codes is new for CY 2022. CMS is not proposing the RUC recommended Work values because they are higher than other similar codes with 10-day global periods,

intraservice and total time. CMS is proposing a Work RVUs of 7.15 and 3.77, respectively. CMS is proposing the RUC recommended direct PE inputs without refinement for 646X0; since 646X1 is an add-on code it does not have any direct PE inputs.

Cholangiography and/or Pancreatography X-Rays at Surgery Add-On (CPT code 74301)

The RUC recommended CPT® 74301 be deleted for October 2020. The application for deletion was submitted by specialty societies but rescinded after a request from the dominant user of the code, general surgery. The RUC recommended to maintain the Work RVU value of 0.21. It was not resurveyed due to low utilization and difficulty with obtaining the necessary threshold of surveys. CMS is proposing the RUC recommended Work RVU. As an add-on code there are direct PE inputs.

Comments Requested for Impact of Infectious Disease on Codes and Ratesetting

CMS is seeking comments on the impact of infectious disease on codes and ratesetting, specifically the impact and types of resource costs that may not be fully reflected in payment rates for existing services or could be accounted for in establishing new payment rates. CMS is seeking comments about additional ways to account for PHE-related costs. They are also seeking if CMS should make changes to payments for services or develop separate payment for services in future rulemaking.

Addressing Changes to Evaluation and Management (E/M) Services

CMS indicated when the American Medical Association (AMA) adopted the new guidelines for outpatient and office setting E/M visits, CMS also adopted the changes. In the months since implementation, CMS indicated there was a need for clarification or adjustment to previous guidelines to align all guidance more fully with the updates. To do the CMS specifically addressed a few areas.

- Split (or Shared) Visits
- New and Established Patients, and Initial and Subsequent Visits
- Payment for the Services of Teaching Physicians

Split (or Shared) Visits

CMS indicated the guidelines do not address who to bill the visit under when performed by different practitioners, whether a substantive portion must be performed by the billing practitioner, whether practitioners must be in same group, or the setting where the split (or shared) visits may be furnished to be billed.

The AMA within the 2021 CPT® E/M Guidelines states, *“A split or shared visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physicians and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for split or shared visits (that is, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).”*

CMS is proposing to define a split (or shared) visit as an E/M visit performed (split or shared) by both a physician and nonphysician practitioner (NPP) who are in the same group in accordance with applicable laws and regulations. The visit is provided in a facility setting in which payment for services furnished incident to is prohibited. In the nonfacility setting, when the physician and NPP each perform components of the visit, it can be billed under the physician if the incident-to criteria are met. The services are provided in accordance with applicable laws and regulations, specifically either the physician or NPP could bill the payer directly for the visit in the facility setting, rather than bill as a split (or shared) visit. CMS is also proposing to allow for split (or shared) visits to be billed for both new and established E/M patient visits.

CMS is also clarifying the only the physician or NPP who performs the substantive portion of the split (or shared) visit) bills for the visit. CMS is defining “substantive portion” to mean more than half of the total time spent by the physician or NPP performing the visit. Due to the need to determine the amount of time spent by each entity, CMS is recommending documentation of the time is included in the note, even if medical decision making (MDM) method is selected to code the visit. In addition, the entity who performs the substantive portion of the visit is the one to sign and date the note, but documentation should include the names and credentials of both entities.

CMS is also proposing the total time between the physician and NPP are totaled, the one with the more than half time will bill the visit based on total time documented. CMS has also proposed the prolonged services could be billed in addition to the visit when time-based method is used with the total time between the two entities used for billing.

CMS has also proposed a list of services which would count toward the total time for determining the substantive portion. Activities include preparing to see the patient (for example, review of tests), obtaining and/or reviewing separately obtained history, performing a medically appropriate examination and/or evaluation, counseling and educating the patient/family/caregiver, ordering medications, tests, or procedures, referring and communicating with other health care professionals (when not separately reported), documenting clinical information in the electronic or other health record, independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver, care coordination (not separately reported).

CMS also outline items that would not count toward time spent in the visit performance of other services that are reported separately, travel, or teaching that is general and not limited to discussion that is required for the management of a specific patient.

CMS is also proposing to create a modifier for billing purposes to identify the visit as a split (or shared) visit. This will allow Medicare to collect data on the frequency and quality of visits provided in part by NPPs but paid to physicians for the full rate.

If the physician and NPP are not in the same group, they would each be expected to bill independently based on the full E/M criteria for the work provided. If neither of them meets the criteria to bill a visit, modifier 52 for reduced services cannot be applied to the E/M visit codes. In this scenario, no visit would be billable by either entity.

Payment for the Services of Teaching Physicians

Stakeholders have requested guidance on how time spent by the resident should be counted when selecting the appropriate E/M office visit level. Within section 1842(b) of the Act specifies *“in the case of physicians’ services furnished to a patient in a hospital with a teaching program, the Secretary shall not provide payment for such services unless the physician renders sufficient personal and identifiable physicians’ services to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought. Regulations regarding PFS payment for teaching physician services”*.

CMS is proposing when total time is used to determine the appropriate E/M office visit level, only the time the teaching physician was present can be included. Medicare already makes payment for the program’s share of the resident’s involvement, due to this CMS does not feel it would be appropriate to count the resident time toward the total time, only that of the teaching physician would count.

Services Provided by Physician Assistants (PAs)

Currently Physician Assistants (PAs) cannot bill independently for their services. In addition, all payments are made to the PAs employer, not directly to the PA. CMS has proposed to allow for PAs to bill for services directly to Medicare and the reimbursement for those services to be paid directly to the PA, similar to Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) currently effective January 1, 2022. PAs would be allowed to reassign their rights to payments for their services and may choose to incorporate as a group solely comprised of practitioners in their specialty billing in the same manner as NPs and CNSs.

Removal of National Coverage Determination Positron Emission Tomography (PET) Scans

CMS is proposing to remove National Coverage Determination (NCD) 220.6, Positron Emission Tomography (PET) Scans to allow the Medicare Administrative Contractor (MAC) to make the decisions of coverage per their beneficiaries.

Stakeholder feedback suggests the NCD is outdated. It was originally created in 2000 to provide broad nation non-coverage for non-oncologic indications of PET. This in turn created the need for every non-oncologic indication to have an individual NCD to receive coverage. CMS believes by leaving this to the MACs to decide they can provide the necessary immediate means to provide coverage for non-oncologic indications or not.

Appropriate Use Criteria (AUC)

The Protecting Access to Medicare Act of 2014 (PAMA) requires CMS to establish a program to promote the utilization of *appropriate use criteria* (AUC) for advanced diagnostic imaging services. Advanced imaging

services include diagnostic CT, MR, and nuclear medicine exams, including PET. Under PAMA, ordering physicians and practitioners (“ordering professionals”) will be required to consult AUC for all advanced imaging studies billed under the Medicare Physician Fee Schedule, the Outpatient Prospective Payment System, and the Ambulatory Surgical Center Payment System, including those performed in a physician office, hospital outpatient department (including emergency department), IDTF, or ambulatory surgery center.

PAMA called for ordering professionals to begin consulting AUC by January 1, 2017, but that deadline was pushed back several times. In the 2018 MPFS Final Rule, CMS announced the consultation requirement would go into effect January 1, 2020. In January 2020, a one year “educational and operations testing period” began which CMS extended to two years by posting an update on their AUC webpage in August 2020.

In the 2022 MPFS Proposed Rule, CMS expressed concerns around the complexities, scope and application of AUC program claims processing edits and is requesting stakeholder feedback regarding the implementation and claims processing issues and the start date of the payment penalty phase. Additionally, CMS acknowledges that due to the challenges and practice disruptions experienced during the PHE for COVID-19, additional time may be needed to prepare for the payment penalty phase.

CMS believes that the earliest that their claims processing system can begin screening claims using the AUC program claims processing edits for the payment penalty phase is October 2022. Since this timing does not align with the typical CMS annual update cycle, CMS believes that the earliest practicable effective date for the AUC program claims processing edits and payment penalty phase would be January 1, 2023. Therefore, CMS’s proposal is a flexible effective date for AUC program claims processing edits and payment penalty phase to begin the later of January 1, 2023, or the January 1 that follows the declared end of the PHE for COVID-19.

Submitting Comments

Comments to CMS regarding the MPFS proposed rule must refer to file code **CMS-1751-P** and be received no later than **5 pm EST September 13, 2021**. Electronic submission is encouraged by CMS, <http://www.regulations.gov>. Follow the instructions under the “submit a comment” tab.