CY 2021 Final Rule Summary
Provided for SIR
Medicare Physician Fee Schedule (MPFS)
December 6, 2020

Introductory Summary

On December 1, 2020, the Centers for Medicare and Medicaid Services (CMS) issued the final rule for the Medicare Physician Fee Schedule (MPFS) for CY 2021.

MPFS Final Rule

The CY 2021 final rule is 2165 pages in length and located in its entirety at the following link: https://www.cms.gov/files/document/12120-pfs-final-rule.pdf. The format of the following information is intended to serve as a summary to the final changes and readers are encouraged to view the document in its entirety for further details.

Payment Rates

CY 2021 is the second year in which there is no specific increase to the conversion factor (CF) as it is frozen and CY 2020's CF, pending any adjustments due to budget neutrality. As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), beginning in CY 2020 the CF is frozen at the previous year's value with no increases for the next five years. The CY 2020 CF is $36.0896, this value is still used for CY 2021 with direct adjustment.

CMS' must remain budget neutral, by maintaining expenditures within $20 million plus or minus each year relative to the increases and/or decreased of the relative value units (RVUs). When it is projected the impact from any RVU changes will be outside the expected budget, a budget neutrality factor is applied to the CF to bring it back into range and maintain budget neutrality. CMS is applying a minus 10.20 percent budget neutral adjustment to the CF, this is a decrease from the proposed adjustment of minus 10.61 percent. Regardless, the budget neutrality factor adjustment will result in an overall decrease in payments for CY 2021, with a CF value of $32.4085.

Table 104 from the final rule outlines the projected impacts:

TABLE 104: Calculation of the CY 2021 PFS Conversion Factor

CY 2020 Conversion Factor		36.0896
Statutory Update Factor	0.00 percent (1.0000)	
CY 2021 RVU Budget Neutrality Adjustment	-10.20 percent (0.8980)	
CY 2021 Conversion Factor		**32.4085**

The following table outlines the combined impact per specialty of the RVU changes for CY 2021.

TABLE 106: CY 2021 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	$499	3%	3%	0%	7%
Interventional Radiology	$936	-3%	-5%	0%	-8%
Radiology	$5,275	-6%	-4%	0%	-10%

** Column F may not equal the sum of columns C, D, and E due to rounding.

Within the final rule, CMS indicated the most widespread impacts to specialties of the RVU changes resulted from misvalued code adjustments for new and revised codes. Specialties such as endocrinology, rheumatology, family practice and hematology/oncology will experience increases when compared to other specialties, this is due primarily to the increases in the values for the office/outpatient evaluation and management (E/M) visits. However, there are also increased payments which resulted from the updates to supply and equipment pricing and indirect practice expense (PE) allocations for some office-based services.

The largest impact to the Physician Fee Schedule (PFS) is due to the office/outpatient E/M visits have been restructured for 2021; they currently make up 20 percent of the total PFS spending. Changes to the E/M visits included adjusted values to the different level of office/outpatient codes, the addition of add-on codes for complexity of services and an add-on code for prolonged service.

The requirement for Medicare to remain budget neutral means when there are increases in valuation to one or multiple specialties, it must be taken or adjusted from another specialty. To account for the increases to the specialties mentioned above, CMS has finalized estimated impacts for several specialties which are negative. The impacted specialties most impacted include, radiology, nurse anesthetists, pathology, and cardiac surgery. As mentioned, the negative impact to specialties is primarily attributed to the office/outpatient E/M visit code valuations and phase-in of previously finalized adjustments to supplies and equipment.

Comments were submitted to CMS regarding the application of budget neutrality resulting in the proposed rule cuts. Suggestions to the Health and Human Services Secretary ("Secretary") included an application of a waiver in response to the public health emergency (PHE) for COVID-19 to implement changes to the E/M valuations without application of budget neutrality. Other comments received included requesting those specialties that do not bill predominantly for E/M services be exempt from the valuation impacts due to the budget neutrality. In response CMS stated the Secretary does not have the authority to apply waivers and make changes to the PFS budget neutrality related to the PHE for COVID-19. In addition, section 1848 of the Act does not permit the Secretary to exclude or exempt specialties from application of budget neutrality adjustments to reimbursement.

Valuation of Specific Codes for CY 2021

Within the CY 2021 proposed and final rule publications, CMS addressed quite a few of the misvalued and/or proposed value changes to specific series of new and established CPT® codes. CMS explains the rationale for the proposed changes are based on values recommended by the Relative Value Scale Update Committee (RUC) and other organizations which CMS looks to for assistance in setting appropriate values for codes.

The following is a list of some of the pertinent codes selected for valuation by CMS in the final rule.

Fine Needle Aspiration (CPT® codes 10021, 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, and 10012)

CMS did not propose changes or revaluation of the fine needle aspiration (FNA) codes. In the CY 2021 PFS final rule CMS did adjust the work RVUs for seven of the ten new codes as recommend by the RUC, while adjusting the other three (10021, 10005, and 10009) without agreement with RUC recommended values. Comments by the RUC stated CMS had misvalued codes by double counting utilization.

CMS continues to reiterate they do not agree with the RUC and the RUC had opportunity to comment on the proposed valuations by CMS but did not submit any comments. Due to this, CMS believes there are no issues with the assigned values for the FNA codes and did not finalize any changes for CY 2021.

Lung Biopsy-CT Guidance Bundle (CPT® code 32408)

CPT® codes 32405 (*Biopsy, lung or mediastinum, percutaneous needle*) and 77012 (*Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation)* were identified by AMA as a pair of codes reported by the same National Provider Identifier (NPI) on claims ≥75 percent of the time.

Effective January 1, 2021 code 32405 is deleted and replaced with code 32408 *(Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed).* CMS did not agree with all of the RUC recommended values, in the end CMS finalized what they proposed for the work and direct PE RVUs for code 32408 without modification.

X-Ray of Eye (CPT code 70030)

CMS identified code 70030 through the updated screen and was found to have a utilization of over 20,000. Due to this, a review of the code was performed for potential misvaluation. CMS proposed the RUC recommended direct PE RVUs and finalized without refinement.

CT Head-Brain (CPT codes 70450, 70460, and 70470)

Code 70450 (*Computed tomography, head or brain; without contrast material*) was nominated for review by a stakeholder citing reports by Government Accountability Office (GAO) and Medicare Payment Advisory Commission (MedPAC) the code may be misvalued. This code belongs to a family of codes, due to this all of the codes in the family were included. After consideration of comments, CMS finalized the proposed work RVUs for each code in the family.

Screening CT of Thorax (CPT codes 71250, 71260, 71270, and 71271)

HCPCS code G0297 (*Low dose ct scan (ldct) for lung cancer screening*) was identified with utilization over 30,000 in CY 2017. It was recommended to the AMA to create a permanent code so in May 2019, the CPT® Editorial Panel revised three CT codes and added a code to distinguish a CT for low dose lung cancer screening, 71271 *(Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)).* CMS did not agree with the RUC recommendations for RVUs and proposed different values, this included matching the work RVUs for codes 71250 and 71271. CMS finalized their proposed values.

X-Ray Bile Ducts (CPT codes 74300, 74328, 74329, and 74330)

CPT® codes 74300 *(Cholangiography and/or pancreatography; intraoperative, radiological supervision and interpretation)* and 74328 *(Endoscopic catheterization of the biliary ductal system, radiological supervision and interpretation)* were identified as part of the screen in which utilization was over 30,000 in 2017. Codes 74329 and 74330 are part of the family, so a review was extended to all of the codes. None of the codes have direct PE inputs and CMS did not propose any. CMS did not agree with the RUC valuations for the codes and finalized what was proposed for the work RVUs for the codes in this family.

Venography (CPT codes 75820 and 75822)

CPT® 75820 *(Venography, extremity, unilateral, radiological supervision and interpretation)* was identified for utilization of over 20,000 claims in a year. Code 75822 was included in the review as part of the family of codes. CMS did agree with the RUC recommended values for work RVUs and finalized as proposed.

Medical Physics Dose Evaluation (CPT code 76145)

A new code for CY 2021 is 76145 *(Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report (medical physicist/dosimetrist).* This code does not include any work RVUs as there is no valued physician work. Instead this code is valued for only PE RVUs and reflects the work of the physicist for interventional radiology and cardiology procedures where the skin dose due to the utilization of fluoroscopy exceeds the institutional threshold. CMS has finalized this code as proposed and after comments is removing it from the Deficit Reduction Act (DRA) cap (OPPS cap) because it is not an imaging service.

Interim Final Rule with Comment Period for Coding and Payment for Personal Protective Equipment (PPE) (CPT code 99072)

The CPT® Editorial Panel released CPT® code 99072 after the release of the MPFS proposed rules. During the comment period stakeholders reached out to CMS for immediate consideration of valuation of code 99072 due to the expenditures incurred by providers in response to COVID-19. Requests were for valuation of direct PE inputs for the supplies and clinical staff time beyond the services it may be provided with.

Due to the increased costs incurred by stakeholders, CMS has finalized on an interim basis an increase in pricing for several supplies based on submitted invoices for code 99072. These supplies included N95 masks, surgical masks, and face shields.

Evaluation and Management (E/M) Guidelines

Evaluation and Management (E/M) visits comprise nearly 40 percent of allowed charges for Physician Fee Schedule (PFS) services, and office/outpatient E/M visits make up nearly 20 percent of the allowed PFS charges. Nearly all specialties utilize and bill for E/M visits, for some this comprises the bulk of their charges. For other specialties that are more procedural based, the bulk of services billed are not E/M. Due to the volume of E/M

visits billed each year and the fact the guidelines had not been updated since 1995 and 1997, CMS and the AMA have been working to revamp the office and outpatient new and established patient visits.

After publication of the CY 2019 MPFS final rules, it was clear CMS was making sweeping changes to Evaluation and Management (E/M) guidelines. Most of the changes were slated for CY 2021 as a means to give stakeholders time to prepare and the AMA time to jump on board and align their guidelines with CMS.

In the CY 2020 MPFS ruling, CMS outlined cancelation of most if not all of the proposed changes and adjusted to the initial updates for E/M released by the AMA for CY 2021. CMS indicated they received many thousands of comments to the CY 2020 proposed ruling specific to E/M changes.

CMS did not propose new changes to the office and outpatient E/M visits from what was finalized in the CY 2020 final rule. In the MPFS final rule CMS did follow as proposed the new HCPCS for complex services, but they also changed course and instead of accepting the CPT® code for prolonged services by creating a new HCPCS code instead.

CMS had proposed a new code to account for complexity of services provided to new and established patients. CMS indicated they believe the updated definitions for CPT® 99202-99215 reflect the work provided in a "typical" office outpatient visit; however, for some specialties they do not adequately capture the resources associated with patient care. CMS had proposed a HCPCS add-on code previously represented by temporary code GPC1X, and finalized as G2211 *(Visit complexity inherent to evaluation and management associated with medical care services that serve as the continuing focal point for all needed health care services and/or with medical care services that are part of ongoing care related to a patient's single, serious condition or a complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)* is for use by any specialty for the ongoing care needs of the patient and potentially evolving illness.

The care provided would be distinctly separate from existing services represented by preventative and care management services. Instead HCPCS add-on code G2211 "*reflects the time, intensity, and PE when practitioners furnish services that enable them to build longitudinal relationships with all patients (that is, not only those patients who have a chronic condition or single-high risk disease) and to address the majority of patients' health care needs with consistency and continuity over longer periods of time."* CMS believes the addition of this code could bolster comprehensive and longitudinal care in the rural setting. The MPFS 2021 national rate, facility and non-facility, for code G2211 is $15.88.

CMS did indicate there would also be circumstances in which it would not be appropriate to bill HCPCS G2211, *"…there are many visits with new or established patients where HCPCS add-on code G2211 would not be appropriately reported, such as when the care furnished during the office/outpatient E/M visit is provided by a professional whose relationship with the patient is of a discrete, routine, or time-limited nature, such as a mole removal or referral to a physician for removal of a mole; for treatment of a simple virus; for counseling related to seasonal allergies, initial onset gastroesophageal reflux disease; treatment for a fracture; and where comorbidities are either not present or not addressed, and/or and when the billing practitioner has not taken responsibility for ongoing medical care for that particular patient with consistency and continuity over time, or*

does not plan to take responsibility for subsequent, ongoing medical care for that particular patient with consistency and continuity over time."

In addition, CMS stated G2211 would not be reported when the office/outpatient E/M visit is reported with a payment modifier, such as -25. In these instances, there are already separate and distinct services provided to the patient beyond the E/M visit, which would preclude the use of the add-on code.

Documentation to support the ongoing relationship between the practitioner and patient could be represented by the patient relationship codes, X1, X2, X3, X4, and X5 established under the Medicare Access and CHIP Reauthorization Act (MACRA). Each of the patient relationship modifiers define the relationship between the patient and practitioner at the time the item or service is furnished.

One of the new CPT® codes created by the AMA for 2021 was 99417 *(Prolonged office or other outpatient evaluation and management service(s) (beyond the total time of the primary procedure which has been selected using total time), requiring total time with or without direct patient contact beyond the usual service, on the date of the primary service; each additional 15 minutes (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services))*. This code is billable with time-based reporting for office/outpatient visit codes that have reached the threshold for a level 5 visit (99205 and 99215).

In the MPFS proposed rule, CMS indicated they did not agree with the time thresholds for the level 5 office/outpatient codes to be able to bill for a prolonged service code as outlined by the AMA. For example, code 99215, level 5 established outpatient visit, the time range is 40-54 minutes. According to CMS, if the billing practitioner spent 55 minutes with the patient, they could not bill the prolonged services code in addition to the level 5 visit code. They indicated if they allowed this, the practitioner would be double dipping their time as the prolonged services code represents 15-minute increments. In the scenario presented, the practitioner would be double counting 14 minutes, the last 14 minutes to meet the top threshold for 99215 and the first 14 minutes of the prolonged service to meet the additional 15 minutes.

CMS believes when the practitioner uses the time-based method, the prolonged services code could be selected when the outpatient office visit level 5 is exceeded by at least 15 minutes on the date of service of the actual visit. For example, code 99215 as described above have a time threshold of 54 minutes, in order to bill for prolonged services CMS believes the visit must last at least 69 minutes, this is 15 more than the top threshold of 54 minutes and is completely separate time from time counted for the actual visit level.

To remedy the discrepancies in reporting for prolonged services with office/outpatient visits, CMS created the HCPCS add-on code G2212 *(Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)."* In addition, CMS states, *"(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes))."*

Utilizing tables CMS provided as part of the MPFS proposed rule which listed temporary code 99XXX, now replaced with G2212, the application of this time-based code might look something like this.

Prolonged Office/Outpatient E/M Visit Reporting - New Patient	
CPT Code(s)	**Total Time Required for Reporting**
99205	60-74 minutes
99205 x 1 and G2212 x 1	89-103 minutes
99205 x 1 and G2212 x 2	104-118 minutes
99205 x 1 and G2212 x 3 or more for each additional 15 minutes	119 or more
Prolonged Office/Outpatient E/M Visit Reporting - Established Patient	
CPT Code(s)	**Total Time Required for Reporting**
99215	40 -54 minutes
99215 x 1 and G2212 x 1	69-83 minutes
99215 x 1 and G2212 x 2	84-98 minutes
99215 x 1 and G2212 x 3 or more for each additional 15 minutes	99 or more

The following table reflect the estimated impacts from CY 2020 to CY 2021 for the office/outpatient E/M visits.

CPT®	Description	2020 Final Payment Rate	2021 Final Payment Rate	Variance	% Change
99202	Office o/p new sf 15-29 min	$ 77.23	$ 69.03	$ (8.20)	-10.6%
99203	Office o/p new low 30-44 min	$ 109.35	$ 106.30	$ (3.05)	-2.8%
99204	Office o/p new mod 45-59 min	$ 167.09	$ 159.77	$ (7.32)	-4.4%
99205	Office o/p new hi 60-74 min	$ 211.12	$ 210.98	$ (0.14)	-0.1%
99211	Office o/p est minimal prob	$ 23.46	$ 22.04	$ (1.42)	-6.1%
99212	Office o/p est sf 10-19 min	$ 46.19	$ 54.12	$ 7.93	17.2%
99213	Office o/p est low 20-29 min	$ 76.15	$ 86.85	$ 10.71	14.1%
99214	Office o/p est mod 30-39 min	$ 110.43	$ 123.48	$ 13.04	11.8%
99215	Office o/p est hi 40-54 min	$ 148.33	$ 172.74	$ 24.41	16.5%

Telehealth Services After the End of the Public Health Emergency

In response to COVID-19 and as part of the Public Health Emergency (PHE), CMS expanded telehealth services to be more broadly accepted and applicable than the system was prior to the pandemic. As part of the waivers and expansion, CMS has allowed for telehealth services to be provided in various settings, including office settings and the patient's home. As part of the Interim Final Rule released in both March and April 2020, CMS indicated when the PHE ends the waivers and expansions would also end and services would revert back to pre-PHE days.

Due to the uncertainty of how long the public health emergency (PHE) will last, and the fact that even when the PHE is declared over the effects of COVID-19 and the response of patients in their lack of comfort to return back to a semblance of "normal" may still linger, CMS has finalized a phased-in end to the waivers and expansions for some items rather than a hard-and-fast stop.

Specifically, CMS proposed and finalized several changes to telehealth services moving forward. Any service added to the Category 3 level of telehealth, will remain on the Medicare telehealth services list through the calendar year in which the PHE for COVID-19 ends. This includes code 77427, *Radiation treatment management, 5 treatments* will as it is not being added to the list permanently. Commenters stated since most radiation oncology practices had been able to secure adequate PPE it was no longer necessary for the radiation treatment management code to be available as telehealth and CMS agreed. In addition, CMS was concerned the components of code 77427 could be adequately provided by real-time audio-video capabilities.

The following table outlines what CMS finalized for services provided by telehealth once the PHE has ended.

TABLE 16: Summary of CY 2021 Services Added to the Medicare Telehealth Services List

Type of Service	Specific Services and CPT Codes
1. Services we are finalizing for permanent addition as Medicare Telehealth Services	• Group Psychotherapy (CPT 90853) • Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99334-99335) • Home Visits, Established Patient (CPT 99347- 99348) • Cognitive Assessment and Care Planning Services (CPT 99483) • Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS G2211) • Prolonged Services (HCPCS G2212) • Psychological and Neuropsychological Testing (CPT 96121)
2. Services we are finalizing to remain temporarily on the Medicare telehealth list through the end of the year in which the PHE for COVID-19 ends (Category 3 services), to allow for continued development of evidence to demonstrate clinical benefit and facilitate post-PHE care transitions.	• Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337) • Home Visits, Established Patient (CPT 99349-99350) • Emergency Department Visits, Levels 1-5 (CPT 99281-99285)* • Nursing facilities discharge day management (CPT 99315-99316) • Psychological and Neuropsychological Testing (CPT 96130- 96133; CPT 96136-96139) • Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161-97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)* • and Hospital discharge day management (CPT 99238- 99239)* • Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT 99469, 99472, 99476)* • Continuing Neonatal Intensive Care Services (CPT 99478- 99480)* • Critical Care Services (CPT 99291-99292)* • End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962)* • Subsequent Observation and Observation Discharge Day • Management (CPT 99217; CPT 99224- 99226)*
3. Services we are not adding to the Medicare telehealth list either permanently or temporarily.	• Initial Nursing Facility Visits, All Levels (Low, Moderate, and High Complexity) (CPT 99304-99306) • Initial hospital care (CPT 99221-99223) • Radiation Treatment Management Services (CPT 77427) • Domiciliary, Rest Home, or Custodial Care services, New (CPT 99324- 99328) • Home Visits, New Patient, all levels (CPT 99341- 99345) • Inpatient Neonatal and Pediatric Critical Care, Initial (CPT 99468, 99471, 99475, 99477)

	• Initial Neonatal Intensive Care Services (CPT 99477) • Initial Observation and Observation Discharge Day Management (CPT 99218 – 99220; CPT 99234- 99236) • Medical Nutrition Therapy (CPT G0271)

* Services that were not proposed as Category 3 additions to the Medicare telehealth list but are being finalized as such.

Telehealth Services Technology Requirements

During the PHE, CMS removed language and allowed for telehealth expanded services to be provided by *"multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner".* This allowed for the use of smartphones to be utilized by practitioners and patients when communicating with audio and video capability. CMS has finalized an update to the last sentence of the Medicare telehealth services regulation which stated: "*prohibits the use of telephones, facsimile machines, and electronic mail systems for purposes of furnishing Medicare telehealth services."* The regulation prohibited the use of telephones and could be confusing when a smartphone and the capabilities for the audio and video are used for the visit. By removing this verbiage, outdated references to technology no longer present and potentially create confusion.

Communication Technology-Based Services (CTBS)

As part of the CY 2019 MPFS Final Rule, CMS created several G-codes for services furnished via telecommunications technology. These services are not considered telehealth services but use telecommunications technology between the practitioner and patient. Two of the codes created include,

- G2010 - *Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment*
- G2012 - *Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion*

The following codes, proposed and finalized by CMS, may be billed by nonphysician practitioners (NPPs). These new codes would also be billable by NPPs, consistent with their scope of practice, for those who cannot bill independently for E/M services. The value of these codes would match G2010 and G2012 respectively.

- G2250 – *Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment*.
- G2251 – *Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot report evaluation and management services, provided to an established patient,*

not originating from a related e/m service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

Audio-only Visits

Prior to the PHE CMS did not provide coverage for telephone services codes, 99441-99443. In large part, this is due to the fact the codes can be provided to the patient, parent, or guardian. CMS does not typically cover services or codes that are not directly provided to the patient themselves. However, as part of the PHE and feedback by stakeholders that most beneficiaries did not want to, know how to, or have the capabilities to use video technology for visits, CMS approved their coverage.

Telecommunication codes available prior to the PHE were only the short duration G-codes referenced above and CMS noted, for some patients, a longer telephone visit is needed. CMS has finalized they will not recognize the telephone codes (99441-99443) under MPFS after the PHE has ended. CMS will assign the status "B" which means "bundled" to the codes once the PHE has ended. CMS believes the CTBS services should be reported for patients outside of the PHE for COVID-19.

On an interim basis, CMS has created a HCPCS code for extended audio-only assessment service. This has been designed for those patients who even after the PHE has ended are still reluctant to return for in-person visits to their practitioner. This will also allow CMS to determine if this code should be made permanent. Effective for CY 2021 HCPCS code G2252 *(Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion.)* is available for use. This code was cross walked to code 99442 for valuation.

HCPCS code G2252 is not a replacement for in-person visit, instead it is meant to assess whether or not one is needed. The only technological requirement for this service is the communication technology must be synchronous, happening in real-time. As with other similarly defined services, if it results from and E/M service in previous seven days or in an E/M or other service within the next 24 hours or soonest available appointment, it is bundled into the in-person service.

Physician Supervision for Telehealth Services

CMS, for the duration of the PHE, has redefined direct supervision under MPFS to be provided through interactive real-time audio-video telecommunication technology. This allows the physician to provide real-time assistance and direction throughout a procedure or service by allowing them to see and interact with the staff member and patient without adding any unnecessary exposure. It is important to note, the supervision adjustments are meant as a minimum requirement. There may be circumstances in which the physical presence of the physician with the patient in the same location is necessary and more appropriate, for example administration of certain drugs or therapies. CMS stressed in these types of scenarios the physician and facility must make the best decision given the situation, even if this means potential exposure due to the nature of the scenario.

CMS has finalized to extend direct supervision expansion under MPFS to end later in the calendar year in which the PHE ends or December 31, 2021. This will allow, along with other waivers and extensions, an easement to the change in supervision than immediate pending the end of the PHE and for physicians and practices to prepare for the change back to the in-person requirement

CMS did clarify, the use of real-time audio and video technology to provide direct supervision under MPFS does not mean the physician must be actively observing and using the technology throughout the entire procedure. Instead the supervising physician is immediately available to engage via the real-time audio and video technology (excluding audio-only) throughout the procedure.

CMS has also received requests for clarification for when a physician and patient are at the same physical location, but the visit is provided using telecommunications technology if this can be billed as a telehealth visit. CMS did provide clarification for this in the Second Interim Final Rule released April 30, 2020. CMS states, "…*if audio/video technology is used in furnishing a service when the beneficiary and the practitioner are in the same institutional or office setting, then the practitioner should bill for the service furnished as if it was furnished in person, and the service would not be subject to any of the telehealth requirements."*

Physician Supervision of Physician Assistant (PA) Services

Requests were made to CMS to allow for PAs to practice medicine without the required supervision by the physician, to align their roles and the regulations similar to those of NPs and CNSs. The scope of work provided by PAs has changed over the years and many provide and deliver health care more broadly than ever before. Many of these changes have resulted in changes to the scope of work and laws in different states. Some states have relaxed their requirements related to the necessary supervision while others have yet to make any changes.

Currently, physicians and NPPs can order diagnostic testing when the results are used by them to manage the patient related to a specific problem. Supervision of diagnostic services has been limited to physicians only as the services are paid under the Medicare Physician Fee Schedule (MPFS) and the minimum levels of supervision are assigned to the code. Supervision does not apply to NPs or Clinical Nurse Specialists (CNSs) as authorized under state law, but CMS is of the understanding in these scenarios the NP or CNS is working in collaboration with the physician.

Outside of the public health emergency (PHE) response to COVID-19, CMS requires general supervision of the PA by the physician. Due to the need to free up physicians and offer flexibility, CMS finalized, on an interim basis (for the duration of the PHE), the ability for NPs, CNSs, PAs, or Certified Nurse-Midwife (CNMs) to provide physician services as if the physician provided them. In addition, this flexibility will allow for payment under Medicare Part B as provided directly and "incident to" their own professional services, within the allowance of their state scope of practice. This specifically will allow NPs, CNSs, PAs, or CNMs to order, furnish directly, and supervise the performance of diagnostic tests as allowed under their state law for the duration of the PHE.

CMS has finalized to allow NPs, CNSs, PAs, CNMs, and CRNAs the ability to supervise diagnostic tests on a permanent basis as allowed by state law and scope of practice. CMS also finalized diagnostic tests performed

by a PA in accordance with their scope of practice and state law do not require the specified level of supervision assigned to individual tests, because the relationship of PAs with physicians would continue to apply.

National Coverage Determination Removal

CMS proposed to continue a process established in CY 2013 of criterion to regularly identify National Coverage Determinations (NCDs) which need to be removed as they no longer contain clinically pertinent and current information. These would be services which are no longer the current medical practice or services used infrequently by beneficiaries. By removing an NCD that once covered certain services, the removal would mean those services would no longer be covered automatically by CMS; however, those services which may have been previously denied could now be covered. This would be due the Medicare Administrative Contractors (MACs) would now be responsible for setting coverage determinations related to the NCDs removed, if the MAC determined it was appropriate to do so.

It has been 5 years since CMS last evaluated older NCDs for removal. CMS recognizes the technology fast out paces the regulations and by being proactive to remove broad coverage determinations, this can open limitations and restrictions to new technologies for stakeholders and CMS. CMS proposed to remove nine NCDs but finalized removal of six.

A few of the NCDs of interest include:

- NCD #110.14 Apheresis (Therapeutic Pheresis) (7/30/1992)
    - CMS believes the MACs can make better decisions for coverage and meeting the needs of Medicare beneficiaries
    - Commenters agreed and disagreed with removal, concerns about inconsistency with coverage and thereby limiting access to care were the primary reasons for opposition
- NCD #110.19 Abarelix for the Treatment of Prostate Cancer (3/15/2005)
    - CMS believes this technology is obsolete and no longer marketed
- NCD#220.6.16 FDG PET for Inflammation and Infection (03/19/2008)
    - CMS indicated they would ensure contractors have the authority and language necessary in the NCD 220.6 (Positron Emission Tomography (PET) Scans) to make a coverage determination when claims are submitted for PET for Inflammation and Infection
    - CMS has indicated claims will be adjudicated appropriately retroactive to the effective date of the NCD, in this case the final rule.

After consideration of comments CMS did not remove the following NCDs:

- NCD 110.14 Apheresis,
- NCD 190.1 Histocompatibility Testing, and
- NCD 190.3 Cytogenetic Studies.

CMS did finalize the removal of the following NCDs:

- NCD 20.5 Extracorporeal Immunoadsorption (ECI) Using Protein A Columns,
- NCD 30.4 Electrosleep Therapy,
- NCD 100.9 Implantation of Gastrointestinal Reflux Devices,

- NCD 220.2.1 Magnetic Resonance Spectroscopy, and
- NCD 220.6.16 FDG PET for Inflammation and Infection
- NCD #110.19 Abarelix for the Treatment of Prostate Cancer
    - The Abarelix NCD was missing from the list provided by CMS, but within the final rule they indicated it was changing to MAC discretion, so it appears an error it was left off the list