CY 2022 Final Rule Summary
Medicare Physician Fee Schedule (MPFS)

On November 2, 2021, the Centers for Medicare and Medicaid Services (CMS) issued the final rule for the Medicare Physician Fee Schedule (MPFS) for CY 2022.

The CY 2022 final rule is 2414 pages in length and located in its entirety at the following link: https://www.federalregister.gov/public-inspection/2021-23972/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 finalized a budget neutral adjustment to the conversion factor (CF) of -0.10 percent, originally proposed to be -0.14 percent. Applying this to a conversion factor of $33.6319, the 2021 CF minus the 3.75 percent increase outlined as part of the Consolidated Appropriation Act of 2021, which CMS cannot legally extend for 2022, changed the value of the 2021 CF to $34.8931. Using this adjusted CF, the final CY 2022 CF is $33.5983 and slightly higher than proposed.
- The lowering of the CF does result in decreases for many specialties and their estimated impacts; however, CMShas also applied additional decreases to many of the Practice Expense (PE) values which create a deepercut to specialties such as interventional radiology, radiation oncology, vascular surgery, and cardiology. The negative impacts are specifically related to the PE values for equipment and clinical labor and reflect changes that take place within the pool of total Relative Value Units (RVUs). The changes for 2022 per CMS "*result from finalized policies within BN* [budget neutrality] *(such as the revaluation of E/M codes in CY 2021 or the clinical labor pricing update in CY 2022) but does not include any changes in spending which result from finalized policies outside of BN"*.
    - Estimated impacts for select specialties are as follows:
        - Interventional Radiology -5% (proposed to be -9%)
        - Radiology -1% (proposed to be -2%)
        - Interventional Pain Management 0% (proposed to be 1%)
- CMS provided several responses to the comments submitted related to the clinical labor pricing update. CMS had proposed to adjust clinical labor values for the first time in 20 years in a single budget neutral adjustment. After considerable push-back CMS has finalized the adoption of a 4-year phase-in which aligns with other policy adjustments made by CMS to RVUs. The clinical labor adjustment when split over four years still negatively impacts interventional radiology services, but to a lesser impact each year.
    - CMS isolated the estimated effect of the labor pricing update on specialties as follows:
        - Interventional Radiology – Y1 = -2%, fully updated total -6% (rounded total over 4 years)
        - Radiology – Y1 = 0%, fully updated total -1%
        - Interventional Pain Management – Y1 = 0%, fully updated total -1%
- CMS moved forward with several revisions to the clinical labor pricing values for a variety of clinical

labor types. For example, CMS proposed to utilize the BLS category 29-9000 (Other Healthcare Practitioners and Technical Occupations) at $27.20 for Angio Technician. After submission of additional salary data CMS selected Lab/Histotechnologist clinical labor type instead of the recommended utilization of level IV certified Radiologic Technologist. According to CMS the median hourly rate of $26.63 better aligned with the data available from Salary Expert than the proposed value or recommendations from commenters. This is an increase to the values last established in 2002 but did not follow the recommendations by SIR.

- CMS included several codes and code sets for valuation for CY 2022. Some are new codes and others were recommended or triggered per the screening tool.
    - Trabecular bone score (77089, 77090, 7709, and 77092) – **New for 2022**
        - Finalized RUC recommendations for work and PE
        - Will associate the costs for analysis and licensing fees to indirect costs for codes 77089 and 77091 against recommendations by commenters
    - Needle Biopsy of Lymph Nodes (38505)
        - Finalized proposed work RVU by CMS and RUC PE inputs without refinement
    - Arthrodesis Decompression (63052 and 63053) – **New for 2022**
        - Finalized refinements to the work RVUs which was finalized between the RUC recommendations and CMS proposed values
    - Destruction by Neurolytic Agent (64633, 64634, 64635, and 64636)
        - Finalized same work RVUs for codes 64633 and 64635 and RUC recommended PE inputs without refinement
    - Destruction of Intraosseous Basivertebral Nerve (64628 and 64629) – **New for 2022**
        - Finalized as proposed work RVUs for both codes and accepted RUC recommended PE inputs without refinement for code 64628
    - Cholangiography and/or Pancreatography X-Rays at Surgery Add-On (74301)
        - Finalized CMS proposed work RVUs. No PE inputs were proposed so none were finalized
- CMS finalized use of audio-only technology for mental health conditions. For all other services, two-way, audio/video communication technology is the general standard for telehealth services after the public health emergency ends. Due to this, audio-only codes 99441-99443 will be removed. Temporary Category 3 codes will remain on the telehealth list until end of CY 2023.
- CMS finalized to permanently adopt coding and payment for HCPCS code G2252 (5–10-minute brief medical discussion), originally proposed to be a temporary service.
- CMS addressed changes to evaluation and management (E/M) visits which began in 2021 and specially addressed:
    - Split (or Shared) Visits for new and established patients
        - Only apply in facility setting, does not apply in office setting
        - Finalized definition as proposed
        - Created different billing for split (or shared) visits from transition year 2022 to fully integrated policy year beginning 2023
    - Payment for the Services of Teaching Physicians
        - Teaching physician total time for E/M does not count time resident alone with patient and furnishing care
        - Time counted is related to the activities outlined by CPT® and presence of physician, does

not include teaching time outside management of the specific patient

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

Payment Rates

CY 2022 CMS does not have the authority to reverse and apply the 3.75 percent increase outlined as part of the Consolidated Appropriations Act of2021, which adjusted the finalized CF for 2021. Due to this, for CY 2022 CMS had to use the finalized CF from 2021 minus 3.75 percent. This resulted in a base start for CY 2022 of $33.6319, rather than $34.8931. CMS has originally proposed a budget neutrality adjustment of minus 0.14 percent, but after adjustments in the final rule was lowered to minus 0.10 percent. This all resulted in a finalized CF for CY 2022 of $33.5983.

Table 134 from the final ruling outlines these factors impacting the conversion factor.

TABLE 134: 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	-0.10 percent (0.9990)	
CY 2022 Conversion Factor		**33.5983**

The lowering of the CF does result in decreases for many specialties and their estimated impacts; however, CMS has also applied additional decreases to many of the Practice Expense (PE) values which create a deepercut to specialties such as interventional radiology, radiation oncology, vascular surgery, and cardiology. The negative impacts are specifically related to the PE values for final year of the 4-year of the equipment and year one of the clinical labor value changes and reflect changes within the pool of total Relative Value Units (RVUs). The changes for 2022 per CMS "*result from finalized policies within BN* [budget neutrality] *(such as the revaluation of E/M codes in CY 2021 or the clinical labor pricing update in CY 2022) but does not include any changes in spending which result from finalized policies outside of BN"*.

- Estimated impacts for select specialties are as follows:
  - Interventional Radiology -5% (proposed to be -9%)
  - Radiology -1% (proposed to be -2%)
  - Interventional Pain Management 0% (proposed to be 1%)

Table 136 from the final rule reflects the final estimated combined impact per specialty including Interventional Pain Management, Interventional Radiology, and Radiology regarding RVU changes for CY 2022.

TABLE 136: 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	$865	0%	2%	0%	1%
Interventional Radiology	$465	0%	-5%	0%	-5%
Radiology	$4,257	0%	-1%	0%	-1%

Clinical Labor

Clinical labor rates were last updated in CY 2002 and CMS proposed 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 there is no BLS data available. Selected labor value changes from Table 12 of the final rule are included below. CMS proposed an increase in labor values for all of the labor types reviewed form the 2022 values but decreased many of the final rates per minute from what was proposed. 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).

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 were 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.

After considerable push-back CMS finalized the adoption of a 4-year phase-in which aligns with other policy adjustments when the impact is above a set percentage by CMS to RVUs. The clinical labor adjustment when split over four years still negatively impacts interventional radiology services, but each year has a smaller adjustment than if applied at one time.

To explain how the clinical labor values may be split over four years, CMS provided the following example (Table 10 in the final rule) which shows how the old and new values are combined over the 4-year phase-in.

Table 10: Example of Clinical Labor Pricing Transition

Current Price	$1.00	
Final Price	$2.00	
Year 1 (CY 2022) Price	$1.25	1/4 difference between $1.00 and $2.00
Year 2 (CY 2023) Price	$1.50	1/3 difference between $1.25 and $2.00
Year 3 (CY 2024) Price	$1.75	1/2 difference between $1.50 and $2.00
Final (CY 2025) Price	$2.00	

CMS also moved forward with several revisions to the clinical labor pricing values for a variety of clinical labor types. For example, CMS proposed to utilize the BLS category 29-9000 (Other Healthcare Practitioners and Technical Occupations) at $27.20 for Angio Technician. After submission of additional salary data CMS selected Lab/Histotechnologist clinical labor type instead of the recommended utilization of level IV certified Radiologic Technologist. According to CMS the median hourly rate of $26.63 better aligned with the data available from Salary Expert than the proposed value or recommendations from commenters. This is an increase to the values last established in 2002 but did not follow the recommendations by SIR.

TABLE 12: Finalized Clinical Labor Pricing Update

Labor Code	Labor Description	Source	Current Rate Per Minute	Updated Rate Per Minute	Y1 Phase-In Rate Per Minute	Total % Change
L041A	Angio Technician	L035A*	0.41	0.58	0.45	41%
L041B	Radiologic Technologist	BLS 29-2034	0.41	0.63	0.47	54%
L041C	Second Radiologic Technologist for Vertebroplasty	BLS 29-2034	0.41	0.63	0.47	54%
L043A	Mammography Technologist	BLS 29-1126*	0.43	0.63	0.48	47%
L046A	CT Technologist	BLS 29-2035	0.46	0.76	0.54	65%
L047A	MRI Technologist	BLS 29-2035	0.47	0.76	0.54	62%
L050B	Diagnostic Medical Sonographer	BLS 29-2032	0.50	0.77	0.57	54%
L051B	RN/Diagnostic Medical Sonographer	L051A, BLS 29-2032	0.51	0.77	0.58	51%
L054A	Vascular Technologist	BLS 19-1040	0.54	0.91	0.63	69%
L152A	Medical Physicist	AAPM Data*	1.52	2.14	1.68	41%

*Updated in response to comments.

CMS isolated the anticipated impacts the labor value changes would have on the various specialties and the payment for their services. CMS emphasized the values in Table 13 from the final rule are not the projected impacts by specialty of all of the policies finalized for CY 2022, the values *only* represent the anticipated effect of the isolated clinical labor pricing update (the allowed changes for each specialty therefore may not match the allowed charges listed in the Regulatory Impacts Analysis section of the rule).

TABLE 13: Anticipated Clinical Labor Pricing Effect on Specialty Impacts

Specialty	Allowed Charges (mil)	Fully Updated	Y1 Phase-In Trans
Interventional Pain Mgmt	$897	-1%	0%
Radiology	$4,417	-1%	0%
Vascular Surgery	$1,149	-5%	-1%
Interventional Radiology	$482	-6%	-2%
Diagnostic Testing Facility	$689	-7%	-2%

The clinical labor values remain open for public comment. This means if new data is available which could adjust or update the clinical labor pricing values, it should be made available to CMS for consideration of adjustment to the values over the phase-in period.

Specific Codes and Code Set Valuations

Trabecular bone score (77089, 77090, 7709, and 77092) – **New for 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.

CMS did finalize they will associate the costs for analysis and licensing fees to indirect costs for codes 77089 and 77091 against recommendations by commenters who had requested it be associated as direct practice expense.

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 proposed the RUC (Relative Value Update Committee) recommendations for Work and PE RVS.

Arthrodesis Decompression (63052 and 63053) – **New for 2022**

The codes 63052 *(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 63053 *(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 did not propose the RUC recommended values (5.55 and 4.44 respectively) instead CMS proposed Work RVU of 3.08 for CPT® code 63052 and a Work RVU of 2.31 for CPT® code 63053.

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 (64628 and 64629) – **New for 2022**

CMS did not propose the RUC recommended Work values because they are higher than other similar codes with 10-day global periods, intraservice and total time. CMS proposed a Work RVUs of 7.15 and 3.77, respectively. CMS proposed the RUC recommended direct PE inputs without refinement for 64628; since 64629 is an add-on code it does not have any direct PE inputs.

Cholangiography and/or Pancreatography X-Rays at Surgery Add-On (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 proposed the RUC recommended Work RVU. As an add-on code there are direct PE inputs.

Table 20 from the final rule reflects the current, RUC recommendations and CMS final work RVUs for selected codes.

TABLE 20: CY 2022 Work RVUs for New, Revised, and Potentially Misvalued Codes

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
77089	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	NEW	0.20	0.20	No
77090	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical preparation and transmission of data for analysis to be performed elsewhere	NEW	0.00	0.00	No
77091	Trabecular bone score (TBS), structural condition of the bone microarchitecture; technical calculation only	NEW	0.00	0.00	No
77092	Trabecular bone score (TBS), structural condition of the bone microarchitecture; interpretation and report on fracture risk	NEW	0.20	0.20	No
38505	Biopsy or excision of lymph node(s); by needle, superficial (eg, cervical, inguinal, axillary)	1.14	1.59	1.59	No
63052	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	NEW	4.44	3.19	No
63053	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	NEW	5.55	4.25	No

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
64633	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, single facet joint	3.84	3.42	3.31	No
64634	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); cervical or thoracic, each additional facet joint	1.32	1.32	1.32	No
64635	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, single facet joint	3.78	3.42	3.32	No
64636	Destruction by neurolytic agent, paravertebral facet joint nerve(s), with imaging guidance (fluoroscopy or CT); lumbar or sacral, each additional facet joint	1.16	1.16	1.16	No
64628	Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; first two vertebral bodies, lumbar or sacral	NEW	8.25	7.15	No
64629	Thermal destruction of intraosseous basivertebral nerve, inclusive of all imaging guidance; each additional vertebral body, lumbar or sacral	NEW	4.87	3.77	No
74301	Cholangiography and/or pancreatography; additional set intraoperative, radiological supervision and interpretation	0.21	0.21	0.21	No

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

<u>Split (or Shared) Visits</u>

Per CMS, 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 shred) 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 proposed and finalized to define a split (or shared) visit as an E/M visit performed (split or shared) by both a physicianand nonphysician practitioner (NPP) who are in the same group in accordance with applicable laws and regulations for new and established patient visits. 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 visitin 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 also clarified only the physician or NPP who performs the substantive portion of the split (or shred)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. CMS did make an adjustment to their proposal. CY 2022 will be a transitional year, except for critical care visits, the substantive portion will be defined by one of three key components (history, exam, MDM) or more than half of the total time spent by the physician and NPP performing the split (or shared) visit) and require a yet defined modifier when billed on the claim. To outline the differences between CY 2022 and 2023, CMS provided Table 26 in the final rule to demonstrate the substantive portion as defined for each year.

TABLE 26: Final Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/Nursing Facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

Acronyms: E/M (Evaluation and Management), MDM (medical decision-making).
*Office visits will not be billable as split (or shared) services.

Due to the need to determine the amount of time spent by each practitioner, CMS recommended documentation of the time to be included in the note, even if medical decision making (MDM) method is selected to code the visit. In addition, the practitioner who performs the substantive portion of thevisit is the one to sign and date the note, but documentation should include the names and credentials of both practitioners.

CMS finalized 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. It was also finalized that the substantive portion could be comprised of time with or without direct patient contact. One of the practitioners performing the visit must have face-to-face (in-person) contact with the patient, but it does not have to be the practitioner who performs the substantive portion and billed for the visit. CMS proposed and finalized 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. This would only apply for other outpatient and inpatient/observation/hospital/nursing facility, use of prolonged services would not apply to emergency department and critical care visits.

CMS outlined a list of services which would and would not 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). Items which would not 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.

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 proposed and finalized 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 proposed and finalized to allow for PAs to bill for services directlyto 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 proposed and finalized 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 theirbeneficiaries.

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 is turn created the need for every non-oncologic indication to have an individual NCD to receive coverage. CMS believed 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 acknowledgeddue 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 believed the earliest their claims processing system could begin screening claims using the AUC program claims processing edits for the payment penalty phase was October 2022. Since this timing does not alignwith the typical CMS annual update cycle, CMS believed the earliest practicable effective date for the AUCprogram claims processing edits and payment penalty phase would be January 1, 2023. Therefore, CMS proposed a flexible effective date for AUC program claims processing edits and payment penalty phase to beginthe later of January 1, 2023, or the January 1 that follows the declared end of the PHE for COVID-19.

CMS also finalized when the furnishing professional cannot reach the ordering professional, the furnishing professional may modify the order for advanced diagnostic imaging services with a replacement and/or additional imaging service as outlined in the Medicare Benefit Policy Manual. If the furnishing professional can reach the ordering professional, the ordering professional must consult the AUC for new orders and provide that information with new orders to be included on the claim.

CMS addressed requests by stakeholders regarding use of the extreme and uncontrollable circumstances hardship exception. Stakeholders may attest to a significant hardship exception for the AUC program due to COVID-19 throughout the PHE. CMS also addressed whether an AUC consultation is required on second opinion interpretations. CMS indicated they do believe the AUC consultation does apply to second opinions the same as they do for original patient assessments.