



Summary of Policies in the Calendar Year (CY) 2021 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

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PROVIDER TYPES AFFECTED

This MLN Matters Article is for physicians and other providers who submit claims to Medicare Administrative Contractors (MACs) for services Medicare pays using the Medicare Physician Fee Schedule (MPFS).

PROVIDER ACTION NEEDED

CR 12071 provides a summary of the policies in the Calendar Year (CY) 2021 MPFS Final Rule and makes other policy changes that apply to Medicare Part B. These changes are effective January 1, 2021, and applicable to services you provide throughout CY 2021. Make sure your billing staffs are aware of these updates.

BACKGROUND

Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish, by regulation, a fee schedule of payment amounts for physicians' services for the subsequent year.

We (CMS) issued a final rule that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2021. The final rule also addresses public comments on Medicare payment policies proposed earlier this year. You'll find the final rule at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFSFederal-Regulation-Notices-Items/CMS-1734-F.html>.

The CY 2021 changes are:

Medicare Telehealth Services

We are finalizing the proposal to add several HCPCS codes to the list of telehealth services on a permanent basis. We are also finalizing the proposal to add additional HCPCS codes to the

list of telehealth services on a temporary basis until the end of the CY in which the Public Health Emergency (PHE) for COVID-19 ends or December 31, 2021. The list of codes we added to the telehealth services list are at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>.

Telehealth Origination Site Facility Fee Payment Amount Update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at \$20. For telehealth services provided on or after January 1 of each subsequent CY, Medicare increases the telehealth originating site facility fee by the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Act.

The MEI increase for 2021 is 1.4%. For CY 2021, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge, or \$27.02 (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

Remote Physiologic Monitoring (RPM)

In response to stakeholder questions about RPM, in the CY 2021 MPFS final rule CMS clarified payment policies related to the RPM services described by Current Procedural Terminology (CPT) codes 99453, 99454, 99091, 99457, and 99458. Also, we finalized as permanent policy two modifications to RPM services that were finalized in response to the PHE for COVID-19.

These two policies include allowing you to obtain consent when you furnish RPM services and allowing auxiliary personnel to furnish CPT codes 99453 and 99454 services under a physician's supervision. Specific clarifications related to payment policies are in the Care Management section of the MPFS final rule.

Item for Regulatory Action Regarding Scope of Practice: Supervision of Diagnostic Tests

We are finalizing the proposed policy regarding supervision of diagnostic tests by certain Non-Physician Practitioners (NPPs) with a modification to include Certified Registered Nurse Anesthetists (CRNAs) to the list of NPPs who are eligible under the Medicare Part B program to supervise the performance of diagnostic tests under applicable State law and scope of practice.

While physicians (medical doctors and doctors of osteopathy) were previously the only professionals authorized under Federal regulations at 42 CFR 410.32 to supervise the performance of diagnostic tests; Nurse Practitioners (NPs), Clinical Nurse Specialists (CNSs), Physician Assistants (PAs), Certified Nurse-Midwives (CNMs) and CRNAs are now also eligible to supervise the performance of diagnostic tests providing the tests fall under applicable state laws and scope of practice. Also, these NPPs must meet the supervision requirements under Medicare regulations that govern their respective statutory benefit category.

Medical Record Documentation

In the CY 2020 MPFS final rule, we finalized broad modifications to the medical record documentation requirements for the physician and certain NPPs.

The 2021 finalized rule clarifies that:

- Physicians and NPPs, including therapists, can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the MPFS
- Therapy students, and students of other disciplines, working under a physician or practitioner who furnishes and bills directly for their professional services to the Medicare program, may document in the record so long as it is reviewed and verified (signed and dated) by the billing physician, practitioner, or therapist.

Therapy Assistants Furnishing Maintenance Therapy

We are finalizing the part B policy for maintenance therapy services that was adopted on an interim basis for the PHE for COVID-19 in the May 1st COVID-19 Interim Final Rule with Comment Period (IFC).

This finalized policy allows:

- Physical Therapists (PT) and Occupational Therapists (OT) to delegate the furnishing of maintenance therapy services, as clinically appropriate, to a Physical Therapy Assistant (PTA) or an Occupational Therapy Assistant (OTA)
- PTs/OTs to use the same discretion to delegate maintenance therapy services to PTAs/OTAs that they use for rehabilitative services.

Pharmacists Providing Services Incident To Physicians' Services

We are finalizing the clarification provided in the May 8th COVID-19 IFC ([85 FR 27550 through 27629](#)) that pharmacists fall within the regulatory definition of auxiliary personnel under CMS regulations at 42 CFR Section 410.26. As such, pharmacists may provide services incident to the services, and under the appropriate level of supervision of the billing physician or NPP, if payment for the services isn't made under the Medicare Part D benefit.

This includes providing the services incident to the services of the billing physician or NPP and in accordance with the pharmacist's state scope of practice and applicable state law. However, physicians and other reporting practitioners can't use Evaluation and Management (E/M) visit codes other than CPT code 99211 to report such services as part of an E/M visit, because those E/M visit codes primarily describe work performed by individuals qualified to directly report the service.

Application of Teaching Physician Regulations

In the 2021 Notice of Proposed Rulemaking (NPRM), CMS solicited public comments on whether the policies implemented on an interim basis in the March 31st and May 8th COVID-19 IFCs should be terminated, temporarily extended through the end of the PHE for COVID-19, or made permanent.

- For residency training sites of a teaching setting that are outside of a Metropolitan Statistical Area (MSA), we are finalizing the proposal to permanently implement the policy, for CY 2021, allowing teaching physicians to use audio/video real-time communications technology to interact with the resident through virtual means in order to meet the requirement that they be present for the key portion of the service; including when the teaching physician involves the resident in furnishing Medicare telehealth services.

- For residency training sites of a teaching setting that are outside of an MSA, we are finalizing the proposal to permanently implement the policy allowing teaching physicians involving residents in providing care at primary care centers to provide the necessary direction, management and review for the resident's services using audio/video real-time communications technology for CY2021.
- Within these sites, residents furnishing services at primary care centers may furnish an expanded set of services to beneficiaries, including level 4 of an office/outpatient E/M visit, transitional care management, and communication technology-based services.

These flexibilities don't apply in the case of surgical, high-risk, interventional, other complex procedures, or services performed through an endoscope and anesthesia services.

In order to ensure that the teaching physician renders the patient sufficient personal and identifiable physicians' services; and exercises full, personal control over the management of the portion of the case for which the payment is sought; the documentation in the medical record must clearly reflect how the teaching physician was present to the resident during the key portion of the service. This is in accordance with Section 1842(b)(7)(A)(i)(I) of the Act.

For example, in the medical record, the teaching physician could document their physical or virtual presence during the key portion of the service.

Resident Moonlighting

In the 2021 NPRM, we asked for public comments on whether the moonlighting policy implemented on an interim basis in the March 31st COVID-19 IFC should be terminated, temporarily extended through the end of the PHE for COVID-19, or made permanent.

We are finalizing the proposal to permanently expand the settings in which residents may moonlight to include the services of residents that aren't related to their approved Graduate Medical Education (GME) programs and which are furnished to inpatients of a hospital in which they have their training program for CY2021.

To prevent the potential duplication of payment with the Inpatient Prospective Payment System for GME, the full documentation in the medical record must show that the resident:

- Furnished identifiable physician services that meet the conditions of payment of physician services to beneficiaries in 42 CFR Section 415.102(a),
- Is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed
- Didn't perform these services as part of the approved GME program.

Office/Outpatient E/M Visits

Effective January 1, 2021, we are implementing new coding, prefatory language, and interpretive guidance framework that the American Medical Association Current Procedural Terminology Editorial Panel issued for office/outpatient E/M visits.

Under this new CPT coding framework, history and exam will no longer be used to select the level of code for office/outpatient E/M visits. Instead, an office/outpatient E/M visit will include a medically appropriate history and exam, when performed. The clinically outdated system for

number of body systems/areas reviewed and examined under history and review will no longer apply, and the history and exam components will be performed when they are reasonable and necessary, and clinically appropriate.

The changes will include deletion of CPT code 99201 (*Level 1 office/outpatient E/M visit, new patient*). For levels 2 through 5 office/outpatient E/M visits, selection of the code level to report will be based on either the level of medical decision making (as redefined in the new AMA/CPT guidance framework), or the total time personally spent by the reporting practitioner on the day of the visit (including time with and without direct patient contact).

For office/outpatient E/M visits, the 1995 and 1997 E/M guidelines will no longer be used. For further guidance, see <https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>.

Prolonged Office/Outpatient E/M Visits

We are finalizing HCPCS code G2212 for prolonged office/outpatient E/M visits. G2212 is to be used for billing the MPFS instead of CPT code 99358, 99359 or 99417, with the following descriptor: "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) (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)."

Please see the table, below, which displays the required times for reporting prolonged office/outpatient E/M visits for new and established patients. When the reporting practitioner's time is used to select the office/outpatient E/M visit level, HCPCS code G2212 could be reported when the maximum time for the level 5 office/outpatient E/M visit is exceeded by (at least) 15 minutes on the date of the service.

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

*Total time is the sum of all time, with and without direct patient contact (including prolonged time), spent by the reporting practitioner on the date of service of the visit.

Proposed 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

*Total time is the sum of all time, with and without direct patient contact (including prolonged time), spent by the reporting practitioner on the date of service of the visit.

NOTE: Physicians will use the prolonged preventive services G0513 and G0514 as an add-on to the covered preventive services that you'll find at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html>.

Office/Outpatient E/M Visit Complexity Add-On

Beginning in 2021, there will be a new, Medicare-specific add-on code to report office/outpatient E/M visit complexity. This HCPCS code is 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, or complex condition. (Add-on code, list separately in addition to office/outpatient evaluation and management visit, new or established)."

This code reflects the time, intensity, and practice expense 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. This includes furnishing patients' ongoing services that result in a comprehensive, longitudinal, and continuous relationship with the patient and involves delivery of team-based care that is accessible, coordinated with other practitioners and providers, and integrated with the broader health care landscape.

For example, in the context of primary care, HCPCS add-on code G2211 could recognize the resources inherent in holistic, patient-centered care that integrates the treatment of illness or injury, management of acute and chronic health conditions, and coordination of specialty care in a collaborative relationship with the clinical care team. In the context of specialty care, HCPCS add-on code G2211 could recognize the resources inherent in engaging the patient in a continuous and active collaborative plan of care related to an identified health condition the management of which requires the direction of a clinician with specialized clinical knowledge, skill and experience.

Such collaborative care includes patient education, expectations and responsibilities, shared decision-making around therapeutic goals, and shared commitments to achieve those goals. In both examples, HCPCS add-on code G2211 reflects the time, intensity, and Practice Expense (PE) associated with providing services that result in care that is personalized to the patient. We aren't restricting billing based on specialty but do assume that certain specialties furnish these

types of visits more than others.

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

We are finalizing:

- The proposal to extend the definition of OUD treatment services to include opioid antagonist medications, such as naloxone, that are approved by FDA under Section 505 of the United States Federal Food, Drug, and Cosmetic Act for emergency treatment of opioid overdose.
- The proposed creation of a new add-on code to cover the cost of providing patients with nasal naloxone and pricing this code based upon the methodology set forth in section 1847A of the Act, except that the payment amount shall be Average Sales Price (ASP) + 0.
- Since auto-injector naloxone is no longer available in the marketplace, we are instead finalizing a second new add-on code to cover the cost of providing patients with injectable naloxone and is contractor pricing this code for CY 2021.
- The proposal to apply a frequency limit on the codes describing naloxone, but is allowing exceptions in the case where the beneficiary overdoses and uses the supply of naloxone given to them by the OTP, to the extent that it is medically reasonable and necessary.
- The proposal to allow periodic assessments to be furnished via two-way interactive audio-video communication technology.

Coding and Payment for Evaluation and Management, Observation and Provision of Self-Administered Esketamine Interim Final Rule

In the CY 2020 PFS final rule (84 FR 63102 through 63104), we finalized the creation of two new HCPCS codes, G2082 and G2083 (effective January 1, 2020) on an interim final basis to allow for payment under the MPFS for use of esketamine in services to patients with treatment-resistant depression.

After consideration of public comments, for CY 2021, we are finalizing the proposal to refine the values for HCPCS codes G2082 and G2083 using a building block methodology that sums the values associated with several codes.

Insertion, Removal, and Removal and Insertion of Implantable Interstitial Glucose Sensor System (Category III CPT codes 0446T, 0447T, and 0448T)

Category III CPT codes 0446T, 0447T, and 0448T describe services related to the insertion and removal of an implantable interstitial glucose sensor system, which are currently contractor priced. Given the immediate needs of Medicare beneficiaries with diabetes, including some who could benefit from the use of innovative technologies, in the CY 2020 PFS final rule (84 FR 62627), we requested information from stakeholders to ensure proper payment for this important physician's service for the insertion, removal, and removal and insertion of implantable interstitial glucose sensor system and welcomed recommendations on appropriate valuation for these services to be considered in future rulemaking.

After consideration of public comments, for CY 2021, we are finalizing the work Relative Value Units as proposed for Category III CPT codes 0446T, 0447T, and 0448T, and finalizing the

direct PE inputs as proposed aside from removing the equipment package (EQ392) from the Category III CPT code 0448T.

CT Modifier Reduction List

We are adding HCPCS code 71271 (Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)) to the list of codes contained within CR 9250. CR 9250 lists what CPT codes are subject to a 15% reduction in payment for the technical component for CT services.

For the full list of codes included on the CT modifier reduction list, please see the related article MM9250, which you'll find at <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/Downloads/MM9250.pdf>.

CPT Codes that CMS Finalized as Contractor Priced : Remote Retinal Imaging (CPT code 92229)

We are finalizing CPT code 92229 (Imaging of retina for detection or monitoring of disease; with point-of-care automated analysis with diagnostic report; unilateral or bilateral) for point-of-care automated analysis that uses innovative Artificial Intelligence (AI) technology to perform the interpretation of the eye exam, without requiring that an ophthalmologist interpret the results as a diagnostic service. This code will be contractor priced. As part of this service, the AMA RVS Update Committee recommended a \$25 “per click” analysis fee for remote imaging that is conducted by AI software. As our PE data have aged and AI applications are emerging, we recognize that issues involving the use of AI are complex. While we agree that the costs for AI applications should be accounted for in payment, AI applications aren't well accounted for in our PE methodology.

There are previous approaches that have been used for establishing payments for other services that use algorithms or AI components to render key portions of a service. For example, in the CMS CY 2018 OPFS final rule (82 FR 59284), we discussed the Fractional Flow Reserve Computed Tomography (FFRCT) service. We noted that the service, which we considered to be separate and distinct from the original coronary computed tomography angiography service isn't an image processing service, but rather the diagnostic output from the FFRCT reports functional flow values that can only be obtained using FFRCT. We found FFRCT to be similar to other technologies that use algorithms, AI, or other new forms of analysis to determine a course of treatment, where the analysis portion of the service can't adequately be reflected under the MPFS payment methodology. Accordingly, we established contractor pricing for the service and have continued to gather information from stakeholders on payment that appropriately reflects resource cost for this service under the MPFS payment methodology. Our recent reviews of the overall cost for the service and specifically for the analysis component of the service have shown the costs to be similar to the costs reflected in payment under the CY 2021 OPFS final rule for CPT code 0503T (analysis of fluid dynamics and simulated maximal coronary hyperemia, generation of estimated FFR model).

ADDITIONAL INFORMATION

The official instruction, CR 12071, issued to your MAC regarding this change is available at

<https://www.cms.gov/files/document/r10505cp.pdf>.

If you have questions, your MACs may have more information. Find their website at <http://go.cms.gov/MAC-website-list>.

DOCUMENT HISTORY

Date of Change	Description
December 4, 2020	Initial article released.

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