# Policy Update

## CMS Finalizes 10% Payment Cut, Expands Telehealth Services in 2021 Physician Fee Schedule

On December 1, 2020, the Centers for Medicare & Medicaid Services (CMS) released the CY 2021 Revisions to Payment Policies under the Physician Fee Schedule (PFS) and Other Changes to Part B Payment Policies [CMS-1734-F], which establishes Medicare physician payments and requirements for the Quality Payment Program (QPP) for 2021. This rule includes a significant payment increase for office/outpatient Evaluation and Management (E/M) services, typically delivered by primary care providers and certain specialty physicians. To offset the increased spending resulting from these payment increases, the rule finalizes an unusually large and controversial budget neutrality adjustment, resulting in a physician conversion factor (CF) of $32.4085 for CY 2021, a 10.20% decrease from the 2020 CF of $36.0896.

The impact of this policy varies significantly across specialties, with those that do not generally bill office/outpatient E/M visits potentially facing cuts of as much as 10%, while other specialties are anticipated to see increases of up to 16%. This policy change was announced and finalized in the CY 2020 PFS final rule for implementation in 2021. Physician specialty societies are vigorously pressing for relief and have turned to Congress to resolve the cuts, especially in light of the Coronavirus (COVID-19) pandemic's impact on the financial health of many practices. Currently, bills[1] are pending in Congress that would change CMS's final policies. Resolution of this issue, like many others this year, will be an uphill battle.

This rule also continues the Administration's efforts to increase flexibility to enable providers to better meet demands stemming from the pandemic, including several changes that make permanent or extend COVID-19 flexibilities.

Coding and payment policies for virtual check-in services and personal protective equipment (PPE) have been established on an interim final basis in this rule and are open for comment. Comments for these policies will be accepted until 60 days after the rule is posted for public inspection.

This final rule will be effective January 1, 2021, unless otherwise noted.

- The final regulations are available here.
- A CMS press release is available here.
- A CMS fact sheet is available here.
- The CMS QPP factsheet is available here.

[1] Reps. Bera (D-CA) and Bucshon (R-IN) introduced H.R. 8702, which would direct CMS to essentially maintain payments at 2020 levels for 2021 and 2022 for physicians who were supposed to receive a cut. For those who do not receive a cut, the bill includes a temporary add-on payment. Another bill, H.R. 8505, introduced by Reps. Burgess (R-TX) and Rush (D-IL) would waive budget neutrality for E/M code increases under the Medicare PFS for one year. This would allow physicians who are anticipating a payment increase to receive additional reimbursement, but it would not need to be offset from other fee schedule payments. This change is estimated to cost $10 billion, which would be allocated from unused funds in the Provider Relief Fund. The bill has fewer than 10 co-sponsors.

A comparison of major provisions as proposed and the finalized policies follows.

Major PFS Payment Proposals

- Conversion Factor
- Specialty Impact
- Practice Expense
- Telehealth and Other Remote Services
- Evaluation and Management Services
- Bundled Services
- Scope of Practice
- Potentially Misvalued Codes
- Transitional Care Management Codes
- Opioid Use Disorder Treatment
- National Coverage Determinations

Major Quality Proposals

- Quality Payment Program
- Medicare Shared Savings Program

## Major Payment Proposals

| Proposed Policy | Finalized Policy |
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| **Conversion Factor**<br>*Medicare physician payment is based on the application of a dollar-based conversion factor to work, practice expense (PE) and malpractice relative value units (RVUs), which are then geographically adjusted. Work RVUs capture the time, intensity and risk of the provider. PE RVUs capture the cost of supplies, equipment and clinical personnel wages used to furnish a specific service. Malpractice RVUs capture the cost of malpractice insurance.*<br>**Final Rule Takeaway:** CY 2021 CF decreased to $32.4085, a reduction of 10.20% from CY 2020 CF. | |
| ✓ **The proposed CY 2021 physician CF was $32.2605, in comparison to the CY 2020 physician CF of $36.09.**<br>• This represented a decrease of $3.83 or a reduction of 10.61% from the CY 2020 physician CF.<br><br>✓ **The proposed CY 2021 anesthesia CF was $19.9631, in comparison to the 2020 CF of $22.2016.**<br>• This represented a decrease of $2.24 or a reduction of 10.09% from the CY 2020 anesthesia CF.<br><br>**Rationale for Proposal**<br>• The significant negative adjustments resulted from a statutorily mandated budget neutrality adjustment to account for changes in work RVUs. | ✓ **The final CY 2021 physician CF is $32.4085.**<br>• This represents a decrease of $3.68 or a reduction of 10.20% from the CY 2020 physician CF of $36.09.<br><br>✓ **The final CY 2021 anesthesia CF is $20.0547.**<br>• This represents a decrease of $2.15 or a reduction of 9.67% from the CY 2020 anesthesia CF of $22.2016.<br><br>**Discussion**<br>• CMS largely maintained increases to E/M work RVUs finalized in the CY 2020 PFS final rule for implementation in CY 2021 and other work RVU changes from the CY 2021 proposed PFS. These changes resulted in increased spending above $20 million, the threshold at which the agency must apply a statutorily mandated budget neutrality adjustment to the physician CF.<br>• In the final rule, CMS reduced its utilization estimates of the new E/M add-on code for complex patients (G2211) from |

| Proposed Policy | Finalized Policy |
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| | being reported 100% of the time to 90% of the time. This reduction in utilization likely contributed to the slightly higher (less bad) CF finalized for 2021 relative to the proposed CF.<br><br>• In 2021, certain clinicians will be subject to an additional payment adjustment based on their performance in the 2019 performance year of the Merit-based Incentive Payment System (MIPS) of the QPP, ranging from +1.79% to -7%.<br><br>• Many stakeholders have expressed serious concerns about the level of cuts to physician payments in the midst of a public health crisis and have been urging Congress to act.<br><br>• There has been speculation that a fix to the physician CF might be included as part of an end-of-year COVID-19 relief package, and bills have been introduced in Congress to avert the cut to Medicare physician services. In the current political climate, and with other significant competing COVID-19-related priorities, the likelihood of either bill advancing before January 1, 2021, is uncertain.<br>o H.R. 8702 would effectively freeze payments at 2020 rates for services scheduled to be cut in 2021 for a period of two years. E/M services would be excluded from this hold harmless provision, but the increased work RVU valuation of E/M codes would be allowed to go through. |

| Proposed Policy | Finalized Policy |
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| | ○ H.R. 8505 would provide a one-year waiver of budget neutrality adjustments under the Medicare PFS.<br><br>Further information found in Appendix.<br>• Physician Conversion Factors 2017-2021<br>• E/M 2021 Values |
| **Specialty Impact**<br>*Policy changes related to physician work, PE and malpractice RVUs affect Medicare payment rates for professional services. Every year CMS publishes a table estimating the impact of policies contained in the rule by specialty. The actual impact on individual practices will vary based on service mix. If Congress acts to waive budget neutrality or otherwise dull the effect, the specialty-level impacts could change dramatically.*<br><br>**Final Rule Takeaway:** Impact by specialty ranges from -10% to +16%. | |
| ✓ **Specialty impact in the proposed rule ranged from -11% for radiology and nurse anesthetists/anesthesiology assistants to +17% for endocrinologists.**<br>• While some differences in specialty impact resulted from proposed changes to individual codes, the wide range in specialty impact was largely due to E/M payment changes slated to begin in 2021 and the statutory requirements around budget neutrality.<br><br>• Specialties that do not generally bill office/outpatient E/M visits would experience the greatest decreases, while specialties and practices that bill higher level established patient visits would see the greatest increases. | ✓ **Specialty impact in the final rule ranges from -10% for radiology, nurse anesthetists/anesthesiology assistants and chiropractors to +16% for endocrinologists.**<br>• Independent diagnostic treatment facilities saw their combined impact improve from -6% in the proposed rule to -3% in the final rule. All other specialties experienced minimal changes from the proposed to the final rule, ranging from -1% to +1%.<br><br>Further information found in Appendix.<br>• Specialty Impact Table from CY 2021 Final Rule |

| Proposed Policy | Finalized Policy |
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| **Practice Expense**<br>*PE RVUs capture the costs of operating a practice and are made up of both direct and indirect cost portions. Direct costs are those that can be assigned to a specific service, such as staff time, supplies and equipment. Indirect costs are those that cannot be directly attributed to the provision of a service, such as rent or overhead costs.*<br>**Final Rule Takeaway:** CMS continues to implement updated PE input pricing. | |
| ✓ **For CY 2019, CMS worked with market research company StrategyGen to conduct a study to update direct PE inputs for 2,000+ items of supplies and equipment.**<br>• CMS is phasing in the new pricing over four years.<br>• CY 2021 is the third year of the transition, which means that PE input pricing for the affected items in 2021 will be based on 75% of the new pricing and 25% of the old pricing. | ✓ **The policy will be implemented as proposed.**<br>• Many stakeholders submitted invoices to CMS to request pricing updates. In some cases, CMS accepted the invoice pricing, but in others, CMS did not. Table 10 of the final rule lists updated pricing for affected supplies and equipment.<br>✓ **CMS updated indirect/direct PE allocations for INR monitoring.**<br>• CMS revised the indirect PE factors for home INR monitoring from Independent Diagnostic Testing Facility (IDTF) (50:50 direct:indirect) to General Practice (31:69 direct:indirect) based upon stakeholder input supporting that home INR monitoring suppliers differ from IDTFs on the indirect factors.<br>**Discussion**<br>• CMS appears to be open to receiving public input and reconsidering PE pricing. Stakeholders should continue to engage in the process. |

| Proposed Policy | Finalized Policy |
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| **Final Rule Takeaway:** CMS updates PE input pricing for certain PPE supplies on an interim basis. | |
| ✓ **Following publication of the CY 2021 PFS proposed rule, the CPT Editorial Panel approved the creation of CPT code 99072 (*Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease*).**<br>• Stakeholders requested that CMS immediately consider implementation of relative values and payment for the newly created CPT code 99072 in recognition of the significant costs incurred by practices under the public health emergency (PHE). Stakeholders requested that the implementation be done outside of budget neutrality requirements.<br>• Stakeholders submitted more than 500 invoices and recommended direct PE inputs associated with code 99072. | ✓ **Because payment for the services as described under CPT code 99072 are always bundled into payment for other services, CMS finalized updated supply pricing increases using the submitted invoices.**<br>• CMS added N95 masks (SD344) to the PE inputs and updated pricing for surgical masks and surgical masks with face shield.<br><br>✓ **CMS will not waive the budget neutrality provision for CPT code 99072 because it does not have the authority to do so unless explicitly stated by statute.**<br><br>**Open for Comments**<br>• CMS is accepting comments on its general approach to 99072 and how to capture costs for services that may not include PPE, for which CMS updated prices but whose costs continue to increase. |

**Final Rule Takeaway:** CMS will host town hall to solicit comments on potential refinement to PE methodology.

✓ **CMS expressed interest in potentially refining the PE methodology and updating the data used to make payments under the PFS.**

- Potential options include incorporating market-based data, updating clinical labor data, and using Hospital Outpatient Prospective Payment System data to inform PE relative value inputs.

✓ **CMS contracted with the RAND Corporation to explore potential improvements to the current methodology.**

- CMS invited feedback from all interested parties.

**Rationale for Proposal**

- CMS believes that potential refinements to the PE methodology could improve payment accuracy and strengthen Medicare. CMS's goals are to obtain data both as soon as practicable and in a way that would allow stakeholders and CMS to collectively examine many of the issues identified by CMS's technical expert panel and RAND.

✓ **CMS did not receive specific recommendations for refinements to the PE methodology.**

- Commenters requested that CMS work with stakeholders on data collection efforts. CMS committed to engaging with stakeholders moving forward.
- CMS will host a town hall meeting at a date to be determined.

**Discussion**

- CMS provided few details on the potential refinements to the PE methodology. Interested stakeholders should monitor developments and attend the town hall meeting.

## Telehealth and Other Remote Services

*One of the key changes implemented through COVID-19 waivers was expanded flexibility for telehealth services, which has led to an uptick in the use of telehealth, remote patient monitoring and communication-technology-based services. While stakeholders have largely lauded these changes, there are questions as to how many of the flexibilities will remain after the end of the PHE.*

**Final Rule Takeaway:** CMS finalized an expanded list of telehealth services, but mostly on a temporary basis.

✓ **Nine services were proposed for permanent addition to the Medicare telehealth services list under Category 1.**

✓ **CMS proposed to add a third category of services to the Medicare telehealth services list.**

- Services would be added to the telehealth list under Category 3 on a temporary basis after the termination of the PHE.
- CMS evaluated services to be added to the telehealth service list under Category 3 if there was no increased concern for patient safety or quality of care, and if all elements of the service could be performed via telehealth technologies.
- Temporary additions to the Medicare telehealth services list were proposed to be added until December 31, 2021, or the end of the year in which the PHE expires.

✓ **CMS permanently added all nine proposed services under Category 1 to the Medicare telehealth services list, including G2211 (*E/M add-on code for complexity*) and G2212 (*E/M add-on code for prolonged visit*).**

✓ **CMS added all proposed Category 3 codes to the Medicare telehealth services list and included additional codes under this category.**

✓ **CMS finalized the proposed timeline for the expiration of the temporary codes under Category 3.**

- Services added under this category will expire on December 31, 2021, or the end of the calendar year in which the PHE expires, whichever is later.

✓ **CMS announced a commissioned study**.

- CMS will commission a study of its telehealth flexibilities provided during the pandemic. The study will explore new opportunities for telehealth services, virtual care supervision and remote monitoring to be provided more efficiently and ways the agency can enhance program integrity.

Further information found in Appendix.

- Permanent additions to the Medicare telehealth services list
- Temporary additions to the Medicare telehealth services list

**Final Rule Takeaway:** CMS finalized an interim code for audio-only services beyond the PHE.

✓ **Recognizing the necessity and appropriateness of audio-only interactions, CMS sought feedback from stakeholders related to the appropriate intensity and length of service for a code describing a phone conversation.**

- At the termination of the PHE, CMS will no longer be able to reimburse audio-only services as crosswalked with office/outpatient E/M codes.
- The statute requires telehealth services to have a two-way audio-visual communication technology.

✓ **CMS established a temporary code for audio-only assessment services.**

- CMS established on an interim basis 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).*
- Established work RVU value is 0.50, crosswalked to code 99442, which is generally lower than a Level II or higher E/M visit for an established patient.
- If the audio-only service is performed within seven days of a previous E/M service or results in an E/M service within the following 24 hours, the phone conversation will be bundled into that in-person service.

**Final Rule Takeaway:** CMS finalized remote patient monitoring (RPM) clarifications requiring established patient relationship after the PHE and permitting physicians and non-physicians to furnish RPM services.

✓ **CMS proposed clarifications related to RPM policy, including:**

- Clarifying medical device policy stating that only physicians and non-physician practitioners (NPPs) who are eligible to furnish E/M services may bill RPM services, and that practitioners may furnish RPM services to patients with acute conditions as well as patients with chronic conditions.
- Clarifying the definition of "interactive communication" and that RPMs are E/M services.

✓ **CMS proposed clarifying that following the PHE, CMS will again require that an established patient-physician relationship exist for RPM services to be furnished.**

✓ **CMS proposed as a permanent policy to allow consent to be obtained at the time that RPM services are furnished, and to allow auxiliary personnel to furnish CPT codes 99453 and 99454 services under a physician's supervision.**

- Auxiliary personnel would include contracted employees.

✓ **CMS solicited comments on whether the current RPM codes accurately and adequately describe the full range of clinical scenarios where RPM services may be of benefit to patients.**

✓ **CMS finalized the following proposed policies:**

- Definitions related to the medical device as supplied as part of 99454 (*Remote monitoring of physiologic parameter(s) (eg, weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s) transmission, each 30 days*).
- RPM services can be furnished by physicians and NPPs.
- RPM services can be furnished to patients with acute conditions as well as patients with chronic conditions.
- Patient consent may be obtained at the time that the services are furnished.
- After the expiration of the PHE, an established patient-physician relationship must exist.

✓ **CMS did not comment on the definition of "interactive communication" in the final rule.**

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| | ✓ **CMS clarified reporting of 99091 and 99457.**<br>• In response to public comments, CMS clarified that it believes CPT guidance allows for certain instances where codes 99091 (*Collection and interpretation of physiologic data (eg, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient and/or caregiver to the physician or other qualified health care professional, qualified by education, training, licensure/regulation (when applicable) requiring a minimum of 30 minutes of time, each 30 days*) and 99457 could be reported for the same patient in the same month as long as time was not used to meet the criteria for both codes. |

## Evaluation and Management Services

*In the CY 2020 PFS final rule, CMS established E/M add-on code G2211 to capture the work associated with complex patients with an effective date of CY 2021. Since the code was established, CMS has received feedback from stakeholders that the definition and reporting requirements of the code are unclear.*

**Final Rule Takeaway:** CMS clarified the definition and revised the estimated utilization of new E/M add-on code G2211.

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| ✓ **CMS solicited comments on E/M add-on code for complexity.**<br>• CMS solicited comments on what aspects of the definition of the new add-on code were unclear and how CMS might address those concerns. | ✓ **CMS provided further details on the appropriate use of new E/M add-on code for patient complexity G2211.**<br>• CMS clarified that G2211 would be reported by primary care clinicians or specialists who are serving as the focal point for the patient's care over a period of time.<br>• The code would not be appropriate for discrete or routine services, or services of a time-limited nature. |

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| | • CMS provided a clinical example of the best use of the code for a primary care clinician (68-year-old woman with progressive congestive heart failure, diabetes and gout, on multiple medications, who presents to her physician for an established patient visit).<br><br>✓ **E/M payment increases and reduced documentation requirements will be implemented for CY 2021.**<br>• In 2020, CMS finalized increased payment rates for office/outpatient E/M visits that will go into effect on January 1, 2021.<br><br>• As discussed in more detail elsewhere in this summary, to offset increased spending resulting from the finalized E/M changes work RVU changes, CMS made reductions to the CY 2021 physician CF.<br><br>• Simplified coding and documentation changes for billing these services will also go into effect on January 1, 2021.<br><br>• CMS estimates that the documentation changes will save clinicians 2.3 million hours per year in administrative burden. |

## Bundled Services

*As previously mentioned, CMS will increase payment rates for office and outpatient E/M visits beginning in 2021. In this rule, CMS finalized proposal to make similar increases to the value of many bundled services that are comparable to or include office/outpatient E/M visits.*

**Final Rule Takeaway:** CMS will increase payments for bundled services.

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| ✓ **CMS proposed payment increases to bundled services that aligned with proposed increases to E/M visit codes.**<br>• Services affected by this proposal are comparable to or include office/outpatient E/M visits.<br>• These bundled services include:<br>o End-Stage Renal Disease Monthly Capitation Payment Services<br>o Transitional Care Management Services<br>o Maternity Services<br>o Cognitive Impairment Assessment and Care Planning<br>o Initial Preventive Physical Examination and Initial and Subsequent Annual<br>o Annual Wellness Visits<br>o Emergency Department Visits<br>o Therapy Evaluations<br>o Psychiatric Diagnostic Evaluations and Psychotherapy Services | ✓ **CMS finalized the policy as proposed.** |

## Scope of Practice and Supervision

*The Medicare program has traditionally had a mix of requirements on the level of training needed for services to be covered and paid, with deference to state scope of practice laws for some services, and specific, more restrictive requirements for other services. Several services, when not performed by a physician, require the direct supervision of a physician for the service to be billable to Medicare. While NPPs could perform some of these services, they could not supervise them. Direct supervision in the office setting has previously been defined as the presence of the physician in the office suite. In response to the PHE, CMS modified this requirement to permit direct supervision to be provided by audio/video real-time communications technology. CMS also permitted NPPs to supervise some diagnostic tests during the PHE.*

**Final Rule Takeaway:** Flexibilities regarding scope of practice and supervision introduced during the PHE will persist.

✓ **CMS proposed making flexibilities on supervision and scope of practice introduced during the PHE permanent.**

- Direct supervision may be provided via audio/video real-time communications technology.
- NPPs may supervise diagnostic tests within state scope of practice laws.
- Therapy assistants may provide maintenance therapy in the outpatient setting.

✓ **CMS finalized its proposed changes.**

- CMS codified that until the end of the PHE or December 31, 2021 (whichever comes later), direct supervision may continue to be provided by audio/video real-time communications technology.
- NPPs (*i.e.*, nurse practitioners, clinical nurse specialists, physician assistants, certified registered nurse anesthetists or certified nurse-midwives) may supervise diagnostic tests within the limitations permitted by state scope of practice laws.
- Physical and occupational therapists may delegate the performance of maintenance therapy to a physical therapy assistant or occupational therapy assistant.

## Potentially Misvalued Codes

*The Affordable Care Act directs regular review of fee schedule rates for physician services paid by Medicare, including services that have experienced high growth rates. CMS established the Potentially Misvalued Code process, which is implemented through the annual PFS cycle, to meet this mandate.*

**Final Rule Takeaway:** CMS identified a single code as potentially misvalued for 2021.

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| ✓ **CMS proposed the following as a potentially misvalued code: 22867 (*Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level*).** | ✓ **CMS finalized the policy as proposed.**<br>• The American Medical Association/RVS Update Committee indicated that CPT code 22867 will be placed on a list it calls the "next Level of Interest for review."<br><br>✓ **Additional codes were nominated through the public comment process.**<br>• Stakeholders nominated additional CPT codes as potentially misvalued: G0442 (*Annual alcohol misuse screening, 15 minutes*), G0444 (*Annual depression screening, 15 minutes*), 49436 (*Delayed creation of exit site from embedded subcutaneous segment of intraperitoneal cannula or catheter*).<br><br>• CMS acknowledged these nominations and stated that it intends to research the issues and engage with stakeholders. |

## Transitional Care Management Codes

*Effective January 1, 2013, CMS established transitional care management (TCM) codes (99495, 99496) to report physician or qualifying NPP care management services for a patient following a discharge from a hospital, skilled nursing facility, community mental health center, outpatient observation or partial hospitalization. At the time the TCM codes were established, CMS identified 57 codes that could not be billed simultaneously because of potential duplication of services.*

**Final Rule Takeaway:** CMS will permit 15 new codes to be billed simultaneously with TCM services.

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| ✓ **CMS proposed 15 additional codes that can be billed concurrently with TCM, including 14 codes for end-stage renal disease services and one complex chronic care management service.**<br>• In CY 2020, CMS removed 16 services from this list. CMS noted that utilization of the TCM services was low, and stated that increased utilization of medically necessary TCM services could improve patient outcomes. | ✓ **CMS finalized the policy as proposed.** |

## Opioid Use Disorder Treatment

*In the CY 2020 PFS, CMS established new coding and payment for a monthly bundle of services for the treatment of opioid use disorder (OUD).*

**Final Rule Takeaway:** CMS created add-on codes for nasal and injectable naloxone and established frequency limits.

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| ✓ **CMS proposed to add naloxone to the definition of OUD treatment services to increase access to this critical therapeutic.**<br>• To account for the additional cost for these drugs, CMS proposed to adjust payment for OUD services through two new add-on codes: GOTP1 and GOTP2, for nasal and auto-injector naloxone, respectively. | ✓ **CMS finalized the policy to create two new codes (HCPCS G2215 and G2216) for nasal and injectable naloxone**<br>• This policy expands the definition under code G2216 to include both auto-injector and injectable naloxone. The cost for nasal naloxone is $92.13 and the cost of injectable naloxone will be contractor priced. Both costs include $2.53 for overdose education. |

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| • CMS proposed payment rates for these new add-on codes to be established through the same process used to price the bundled OUD services. | ✓ **CMS finalized frequency limits on the number of add-on codes for naloxone that can be billed per month**<br>• Providers can only bill one supply (two injections) of naloxone per beneficiary every 30 days. |

## National Coverage Determinations

*Medicare coverage is limited to items and services that are reasonable and necessary for the diagnosis or treatment of an illness or injury (and within the scope of a Medicare benefit category). The national coverage determinations (NCDs) are a process managed by CMS, with opportunities for public participation. CMS intermittently reviews NCDs and retires NCDs believed to be outdated or no longer relevant.*

**Final Rule Takeaway:** CMS will retire six NCDs of the nine considered for retirement

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| ✓ **CMS proposed retiring nine NCDs.**<br>• NCD 20.5 Extracorporeal Immunoadsorption (ECI) using Protein A Columns<br>• NCD 100.9 Implantation of Gastroesophageal Reflux Device<br>• NCD 110.19 Abarelix<br>• NCD 30.4 Electrosleep Therapy<br>• NCD 220.2.1 Magnetic Resonance Spectroscopy<br>• NCD 220.6.16 FDG PET for Infection and Inflammation<br>• NCD 110.14 Apheresis (Therapeutic Pheresis)<br>• NCD 190.1 Histocompatability Testing<br>• NCD 190.3 Cytogenetic Studies | ✓ **CMS will retire six NCDs.**<br>• CMS will retire three limited coverage NCDs: NCD 20.5, Extracorporeal Immunoadsorption (ECI) using Protein A Columns, NCD 100.9, Implantation of Gastroesophageal Reflux Device, and NCD 110.19, Abarelix.<br>• CMS will retire three noncoverage NCDs: NCD 30.4 Electrosleep Therapy, NCD 220.2.1 Magnetic Resonance Spectroscopy, and NCD 220.6.16 FDG PET for Infection and Inflammation.<br>• CMS will not retire three limited coverage policies that it considered retiring in the proposed rule: NCD 110.14 Apheresis (Therapeutic Pheresis), NCD 190.1 Histocompatability Testing, and NCD 190.3 Cytogenetic Studies. |

## Major Quality Proposals

| Proposed Policy | Finalized Policy |
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| **Quality Payment Program**<br>*Under the QPP, eligible clinicians elect to either be subject to payment adjustments based upon performance under the MIPS or to participate in the Advanced Alternative Payment Model (APM) track. Eligible clinicians choosing the MIPS pathway have payments increased, maintained or decreased based on relative performance in four categories: Quality, Cost, Promoting Interoperability (meaningful use) and Improvement Activities. Eligible clinicians choosing the APM pathway receive a bonus payment if they meet the qualifications for that track. Because of the current COVID-19 pandemic, CMS said that QPP final policies have been limited to only the highest priorities to continue to advance policy goals of the program while being sensitive to providers responding on the frontlines.*<br>**Final Rule Takeaway:** The MIPS Value Pathway (MVP) is delayed until CY 2022 or later. | |
| ✓ **The MVP participation option was scheduled to begin on January 1, 2021. Because of the COVID-19 pandemic, CMS proposed delaying its implementation.**<br>• The agency did not propose any MVPs in the proposed rule. However, CMS did provide additional information for stakeholders interested in developing MVPs and partnering with the agency.<br>• CMS proposed updates to the MVP guiding principles in response to stakeholder feedback. The updated principles reflect CMS's continued efforts to improve beneficiary care and create measures and activities that reflect care best practices. | ✓ **CMS delayed MVP implementation until CY 2022 or later. The agency did not make any changes to the proposed guiding principles or the MVP development process.**<br>• CMS finalized the proposed guiding principles, including the additional guiding principle intended to support the transition to digital quality measures.<br>✓ **Stakeholders can engage with CMS to develop MVPs.**<br>• CMS provided additional information for stakeholders to engage with the agency.<br>• Template forms to submit proposed MVPs can be downloaded with the QPP Fact Sheet and additional information. |

| Proposed Policy | Finalized Policy |
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| **Final Rule Takeaway:** CMS established a 60-point threshold in MIPS to avoid a negative payment adjustment | |
| ✓ **CMS proposed to lower the previously finalized MIPS performance threshold from 60 points to 50 points for the 2021 performance/2023 payment year because of disruptions caused by the COVID-19 pandemic.**<br><br>✓ **CMS proposed the following MIPS performance category weights:**<br>• Quality: 40%<br>• Cost: 20%<br>• Promoting Interoperability: 25%<br>• Improvement Activities: 15% | ✓ **CMS finalized the 60-point threshold for MIPS participants to avoid a negative payment adjustment for the 2021 performance year.**<br>• The agency reverted to previous finalized policy, as CMS believes this will best incentivize clinician performance.<br><br>✓ **CMS finalized the weights for the MIPS performance categories as proposed.** |
| **Final Rule Takeaway:** Additional changes are necessary for the Advanced APM calculation to ensure that accountable care organizations (ACOs) and other advanced APMs achieve Qualified Participant status and become bonus eligible for the 2021 performance year. | |
| ✓ **CMS proposed excluding prospectively aligned beneficiaries from the attribution-eligible beneficiary count to prevent dilution of MACRA threshold scores.**<br><br>✓ **CMS proposed establishing a targeted review process for Qualifying Participant determinations.** | ✓ **CMS finalized both policies as proposed.** |

| Proposed Policy | Finalized Policy |
|---|---|
| **Medicare Shared Savings Program**<br>*CMS proposed revisions to quality reporting for the Medicare Shared Savings Program (MSSP).*<br>**Final Rule Takeaway:** CMS is phasing in many of the proposed changes to the quality reporting requirements for ACOs. This provides additional time for stakeholders to weigh in on the future direction of the MSSP quality strategy. | |
| ✓ **CMS proposed implementation of a new APM performance pathway for performance year (PY) 2021 and subsequent performance years. CMS stated that the new pathway would streamline reporting requirements and create a complementary path to the MVP, despite the MVP being delayed.**<br>• CMS proposed removing the Web Interface from the submission type options, which would cause significant disruption to ACOs.<br>• CMS proposed increasing the level of quality performance that would be required for MSSPs to share in savings and continue to participate in the Shared Savings Program to the 40th percentile or above.<br>✓ **CMS proposed revisions to the definition of primary care services used in MSSP beneficiary assignment.** | ✓ **CMS will apply the APM Performance Pathway to shared savings program beginning on or after January 1, 2021.**<br>• For PY 2021, ACOs can choose to report 10 measures under the CMS Web Interface or three eCQM/MIPS CQM measures. ACOs will be required to field the CAHPS for MIPS survey, and CMS will calculate two measures using administrative claims data.<br>• The agency will extend the use of the CMS Web Interface as a collection type for CY 2021 and will sunset the Web Interface in CY 2022.<br>• For PY 2022 and beyond, ACOs will be required to report three eCQM/MIPS CQM measures via the APP. ACOs will be required to field the CAHPS for MIPS survey, and CMS will calculate two measures using administrative claims data.<br>• ACOs will meet the quality performance standard if the score is equal to or higher than the 30th percentile. For PY 2023 and beyond, the level will increase to the 40th percentile. |

| Proposed Policy | Finalized Policy |
|---|---|
| | ✓**CMS finalized the proposed changes to the definition of primary care services for beneficiary assignment with a modification to include G2010 and G2012.** |

For more information, contact Paul Gerrard, Deb Godes, Kelsey Haag, Sheila Madhani, Mara McDermott, Kristen O'Brien and Christine Song.

# Appendix:

**Table 1: Medicare Physician Conversion Factor 2017–2021**

| Year | CF | Actual Update (%) |
|---|---|---|
| Jan 1, 2017 | 35.8887 | 0.24 |
| Jan 1, 2018 | 35.9996 | 0.31 |
| Jan 1, 2019 | 36.0391 | 0.11 |
| Jan 1, 2020 | 36.0896 | 0.14 |
| Jan 1, 2021 | 32.4085 | -10.20 |

**Table 2: CY 2021 E/M Values**

| Code | 2020 Work RVU | 2021 Work RVU | % Change |
|---|---|---|---|
| *New Patient Office Visit Codes* | | | |
| 99201 | 0.48 | N/A | N/A |
| 99202 | 0.93 | 0.93 | 0.00% |
| 99203 | 1.42 | 1.60 | 12.68% |
| 99204 | 2.43 | 2.60 | 7.00% |
| 99205 | 3.17 | 3.50 | 10.41% |
| *Established Patient Office Visit Codes* | | | |
| 99211 | 0.18 | 0.18 | 0.00% |
| 99212 | 0.48 | 0.70 | 45.83% |
| 99213 | 0.97 | 1.30 | 34.02% |
| 99214 | 1.50 | 1.92 | 28.00% |
| 99215 | 2.11 | 2.80 | 32.70% |

**Table 3: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty**
*Source: Table 106, CY 2021 MPFS, Display Copy*

| Specialty | Allowed Charges (mil) | Impact of Work RVU Changes | Impact of PE RVU Changes | Impact of MP RVU Changes | Combined Impact |
|---|---|---|---|---|---|
| **Allergy/Immunology** | $ 247 | 5% | 4% | 0% | **9%** |
| **Anesthesiology** | $ 2,020 | -6% | -1% | 0% | **-8%** |
| **Audiologist** | $ 75 | -4% | -2% | 0% | **-6%** |
| **Cardiac Surgery** | $ 266 | -5% | -2% | 0% | **-8%** |
| **Cardiology** | $ 6,871 | 1% | 0% | 0% | **1%** |
| **Chiropractor** | $ 765 | -7% | -3% | 0% | **-10%** |
| **Clinical Psychologist** | $ 832 | 0% | 0% | 0% | **0%** |
| **Clinical Social Worker** | $ 857 | 0% | 1% | 0% | **1%** |
| **Colon And Rectal Surgery** | $ 168 | -4% | -1% | 0% | **-5%** |
| **Critical Care** | $ 378 | -6% | -1% | 0% | **-7%** |
| **Dermatology** | $ 3,767 | -1% | 0% | 0% | **-1%** |
| **Diagnostic Testing Facility** | $ 748 | -1% | -2% | 0% | **-3%** |
| **Emergency Medicine** | $ 3,077 | -5% | -1% | 0% | **-6%** |
| **Endocrinology** | $ 508 | 10% | 5% | 1% | **16%** |
| **Family Practice** | $ 6,020 | 8% | 4% | 0% | **13%** |
| **Gastroenterology** | $ 1,757 | -3% | -1% | 0% | **-4%** |
| **General Practice** | $ 412 | 5% | 2% | 0% | **7%** |
| **General Surgery** | $ 2,057 | -4% | -2% | 0% | **-6%** |
| **Geriatrics** | $ 19 | 1% | 1% | 0% | **3%** |
| **Hand Surgery** | $ 246 | -2% | -1% | 0% | **-3%** |
| **Hematology/Oncology** | $ 1,707 | 8% | 5% | 1% | **14%** |
| **Independent Laboratory** | $ 645 | -3% | -2% | 0% | **-5%** |
| **Infectious Disease** | $ 656 | -4% | -1% | 0% | **-4%** |
| **Internal Medicine** | $ 10,730 | 2% | 1% | 0% | **4%** |
| **Interventional Pain Mgmt** | $ 936 | 3% | 3% | 0% | **7%** |
| **Interventional Radiology** | $ 499 | -3% | -5% | 0% | **-8%** |
| **Multispecialty Clinic/Other Phys** | $ 153 | -3% | -1% | 0% | **-3%** |
| **Nephrology** | $ 2,225 | 4% | 2% | 0% | **6%** |
| **Neurology** | $ 1,522 | 3% | 2% | 0% | **6%** |
| **Neurosurgery** | $ 811 | -4% | -2% | -1% | **-6%** |
| **Nuclear Medicine** | $ 56 | -5% | -3% | 0% | **-8%** |
| **Nurse Anes / Anes Asst** | $ 1,321 | -9% | -1% | 0% | **-10%** |
| **Nurse Practitioner** | $ 5,100 | 5% | 3% | 0% | **7%** |
| **Obstetrics/Gynecology** | $ 636 | 4% | 3% | 0% | **7%** |
| **Ophthalmology** | $ 5,343 | -4% | -2% | 0% | **-6%** |
| **Optometry** | $ 1,359 | -2% | -2% | 0% | **-4%** |
| **Oral/Maxillofacial Surgery** | $ 79 | -2% | -2% | 0% | **-4%** |
| **Orthopedic Surgery** | $ 3,812 | -3% | -1% | 0% | **-4%** |
| **Other** | $ 48 | -3% | -2% | 0% | **-5%** |
| **Otolarngology** | $ 1,271 | 4% | 3% | 0% | **7%** |
| **Pathology** | $ 1,265 | -5% | -4% | 0% | **-9%** |
| **Pediatrics** | $ 67 | 4% | 2% | 0% | **6%** |
| **Physical Medicine** | $ 1,164 | -3% | 0% | 0% | **-3%** |
| **Physical/Occupational Therapy** | $ 4,973 | -4% | -4% | 0% | **-9%** |
| **Physician Assistant** | $ 2,901 | 5% | 2% | 0% | **8%** |

| Specialty | Allowed Charges (mil) | Impact of Work RVU Changes | Impact of PE RVU Changes | Impact of MP RVU Changes | Combined Impact |
|---|---|---|---|---|---|
| **Plastic Surgery** | $ 382 | -4% | -3% | 0% | **-7%** |
| **Podiatry** | $ 2,133 | -1% | 0% | 0% | **-1%** |
| **Portable X-Ray Supplier** | $ 95 | -2% | -4% | 0% | **-6%** |
| **Psychiatry** | $ 1,112 | 4% | 3% | 0% | **7%** |
| **Pulmonary Disease** | $ 1,654 | 0% | 0% | 0% | **1%** |
| **Radiation Oncology and Radiation Therapy Centers** | $ 1,809 | -3% | -3% | 0% | **-5%** |
| **Radiology** | $ 5,275 | -6% | -4% | 0% | **-10%** |
| **Rheumatology** | $ 548 | 10% | 5% | 1% | **15%** |
| **Thoracic Surgery** | $ 352 | -5% | -2% | 0% | **-8%** |
| **Urology** | $ 1,810 | 4% | 4% | 0% | **9%** |
| **Vascular Surgery** | $ 1,293 | -2% | -4% | 0% | **-6%** |
| **TOTAL** | **$ 97,008** | **0%** | **0%** | **0%** | **0%** |

Note: Sum of impact of Work RVU, PE RVU and MP RVU Changes may not equal Combined Impact because of rounding.

**Table 4: Permanent Additions to the Medicare Telehealth Service List**

*Source Table 11: CY 2021 Proposed and Final Additions to the Medicare Telehealth Services List on a Category 1 Basis, CY 2021 MPFS, Display Copy*

| HCPCS | Long Descriptor |
|---|---|
| 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) |
| 90853 | Group psychotherapy (other than of a multiple-family group) |
| 96121 | Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure) |
| 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) |
| 99483 | Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (e.g., basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (e.g., functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (e.g., home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (e.g., rehabilitation |

| HCPCS | Long Descriptor |
|---|---|
| | services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver. |
| 99334 | Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver. |
| 99335 | Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver. |
| 99347 | Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family. |
| 99348 | Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family. |

**Table 5: Temporary Additions to the Medicare Telehealth Services List**

*Source: Table 14: Final Services for Temporary Addition to the Medicare Telehealth Services List, CY 2021 MPFS, Display Copy*

| Service Type | HCPCS | Long Descriptor |
|---|---|---|
| End-Stage Renal Disease Monthly Capitation Payment Services | 90952 | End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month |
| | 90953 | End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month |
| | 90956 | End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month |

| Service Type | HCPCS | Long Descriptor |
|---|---|---|
| | 90959 | End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 1 face-to-face visit by a physician or other qualified health care professional per month |
| | 90962 | End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 1 face-to-face visit by a physician or other qualified health care professional per month |
| Emergency Department Visits | 99281 | Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. |
| | 99282 | Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. |
| | 99283 | Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. |
| | 99284 | Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.<br>Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function. |
| | 99285 | Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function. |
| Domiciliary, Rest Home, or Custodial Care Services, Established Patients | 99336 | Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver. |

| Service Type | HCPCS | Long Descriptor |
|---|---|---|
| | 99337 | Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent with the patient and/or family or caregiver. |
| Home Visits, Established Patient | 99349 | Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family. |
| | 99350 | Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family. |
| Nursing Facilities Discharge Day Management | 99315 | Nursing facility discharge day management; 30 minutes or less |
| | 99316 | Nursing facility discharge day management; more than 30 minutes |
| Psychological and Neuropsychological Testing | 96121 | Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [e.g., acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure) |
| | 96130 | Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour |
| | 96131 | Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure) |
| | 96132 | Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour |

| Service Type | HCPCS | Long Descriptor |
|---|---|---|
| | 96133 | Neuropsychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour (List separately in addition to code for primary procedure) |
| | 96136 | Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; first 30 minutes |
| | 96137 | Psychological or neuropsychological test administration and scoring by physician or other qualified health care professional, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure) |
| | 96138 | Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes |
| | 96139 | Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes (List separately in addition to code for primary procedure) |
| Therapy Services, Physical and Occupational Therapy, All Levels | 97161 | Physical therapy evaluation: low complexity, requiring these components: A history with no personal factors and/or comorbidities that impact the plan of care; An examination of body system(s) using standardized tests and measures addressing 1-2 elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with stable and/or uncomplicated characteristics; and Clinical decision making of low complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 20 minutes are spent face-to-face with the patient and/or family. |
| | 97162 | Physical therapy evaluation: moderate complexity, requiring these components: A history of present problem with 1-2 personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures in addressing a total of 3 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; An evolving clinical presentation with changing characteristics; and Clinical decision making of moderate complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| | 97163 | Physical therapy evaluation: high complexity, requiring these components: A history of present problem with 3 or more personal factors and/or comorbidities that impact the plan of care; An examination of body systems using standardized tests and measures addressing a total of 4 or more elements from any of the following: body structures and functions, activity limitations, and/or participation restrictions; A clinical presentation with unstable and unpredictable characteristics; and Clinical decision making of high complexity using standardized patient assessment instrument and/or measurable assessment of functional outcome. Typically, 45 minutes are spent face-to-face with the patient and/or family. |
| | 97164 | Re-evaluation of physical therapy established plan of care, requiring these components: An examination including a review of history and use of standardized tests and measures is required; and Revised plan of care using a standardized patient assessment instrument and/or measurable assessment of functional outcome Typically, 20 minutes are spent face-to-face with the patient and/or family. |

| Service Type | HCPCS | Long Descriptor |
|---|---|---|
| Therapy Services, Physical and Occupational Therapy, All Levels | 97165 | Occupational therapy evaluation, low complexity, requiring these components: An occupational profile and medical and therapy history, which includes a brief history including review of medical and/or therapy records relating to the presenting problem; An assessment(s) that identifies 1-3 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of low complexity, which includes an analysis of the occupational profile, analysis of data from problem-focused assessment(s), and consideration of a limited number of treatment options. Patient presents with no comorbidities that affect occupational performance. Modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is not necessary to enable completion of evaluation component. Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| | 97166 | Occupational therapy evaluation, moderate complexity, requiring these components: An occupational profile and medical and therapy history, which includes an expanded review of medical and/or therapy records and additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 3-5 performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of moderate analytic complexity, which includes an analysis of the occupational profile, analysis of data from detailed assessment(s), and consideration of several treatment options. Patient may present with comorbidities that affect occupational performance. Minimal to moderate modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 45 minutes are spent face-to-face with the patient and/or family. |
| | 97167 | Occupational therapy evaluation, high complexity, requiring these components: An occupational profile and medical and therapy history, which includes review of medical and/or therapy records and extensive additional review of physical, cognitive, or psychosocial history related to current functional performance; An assessment(s) that identifies 5 or more performance deficits (i.e., relating to physical, cognitive, or psychosocial skills) that result in activity limitations and/or participation restrictions; and Clinical decision making of high analytic complexity, which includes an analysis of the patient profile, analysis of data from comprehensive assessment(s), and consideration of multiple treatment options. Patient presents with comorbidities that affect occupational performance. Significant modification of tasks or assistance (e.g., physical or verbal) with assessment(s) is necessary to enable patient to complete evaluation component. Typically, 60 minutes are spent face-to-face with the patient and/or family. |
| | 97168 | Re-evaluation of occupational therapy established plan of care, requiring these components: An assessment of changes in patient functional or medical status with revised plan of care; An update to the initial occupational profile to reflect changes in condition or environment that affect future interventions and/or goals; and A revised plan of care. A formal reevaluation is performed when there is a documented change in functional status or a significant change to the plan of care is required. Typically, 30 minutes are spent face-to-face with the patient and/or family. |
| | 97110 | Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility |
| | 97112 | Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities |
| | 97116 | Therapeutic procedure, 1 or more areas, each 15 minutes; gait training (includes stair climbing) |

| Service Type | HCPCS | Long Descriptor |
|---|---|---|
| | 97535 | Self-care/home management training (e.g., activities of daily living (ADL) and compensatory training, meal preparation, safety procedures, and instructions in use of assistive technology devices/adaptive equipment) direct one-on-one contact, each 15 minutes |
| | 97750 | Physical performance test or measurement (e.g., musculoskeletal, functional capacity), with written report, each 15 minutes |
| | 97755 | Assistive technology assessment (e.g., to restore, augment or compensate for existing function, optimize functional tasks and/or maximize environmental accessibility), direct one-on-one contact, with written report, each 15 minutes |
| | 97760 | Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes |
| | 97761 | Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes |
| | 92521 | Evaluation of speech fluency (e.g., stuttering, cluttering) |
| | 92522 | Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); |
| | 92523 | Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language) |
| | 92524 | Behavioral and qualitative analysis of voice and resonance |
| | 92507 | Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual |
| Subsequent Observation and Observation Discharge Day Management | 99217 | Observation care discharge day management (This code is to be utilized to report all services provided to a patient on discharge from outpatient hospital "observation status" if the discharge is on other than the initial date of "observation status." To report services to a patient designated as "observation status" or "inpatient status" and discharged on the same date, use the codes for Observation or Inpatient Care Services [including Admission and Discharge Services, 99234-99236 as appropriate.]) |
| | 99224 | Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: Problem focused interval history; Problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit. |
| | 99225 | Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit. |

| Service Type | HCPCS | Long Descriptor |
|---|---|---|
| | 99226 | Subsequent observation care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit. |
| Initial Hospital Care and Hospital Discharge Day Management | 99221 | Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 30 minutes are spent at the bedside and on the patient's hospital floor or unit. |
| | 99222 | Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit. |
| | 99223 | Initial hospital care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit. |
| | 99238 | Hospital discharge day management; 30 minutes or less |
| | 99239 | Hospital discharge day management; more than 30 minutes |
| Critical Care Services | 99291 | Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes |
| | 99292 | Critical care, evaluation and management of the critically ill or critically injured patient; each additional 30 minutes (List separately in addition to code for primary service) |
| Inpatient Neonatal and Pediatric Critical Care, Subsequent | 99469 | Subsequent inpatient neonatal critical care, per day, for the evaluation and management of a critically ill neonate, 28 days of age or younger |
| | 99472 | Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 29 days through 24 months of age |
| | 99476 | Subsequent inpatient pediatric critical care, per day, for the evaluation and management of a critically ill infant or young child, 2 through 5 years of age |
| Continuing Neonatal Intensive Care Services | 99478 | Subsequent intensive care, per day, for the evaluation and management of the recovering very low birth weight infant (present body weight less than 1500 grams) |
| | 99479 | Subsequent intensive care, per day, for the evaluation and management of the recovering low birth weight infant (present body weight of 1500-2500 grams) |

| Service Type | HCPCS | Long Descriptor |
|---|---|---|
| | 99480 | Subsequent intensive care, per day, for the evaluation and management of the recovering infant (present body weight of 2501-5000 grams) |