

CMS Manual System	Department of Health & Human Services (DHHS)
Pub 100-04 Medicare Claims Processing	Centers for Medicare & Medicaid Services (CMS)
Transmittal 10505	Date: December 4, 2020
	Change Request 12071

SUBJECT: 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

I. SUMMARY OF CHANGES: This Change Request (CR) provides a summary of the policies in the CY 2021 Medicare Physician Fee Schedule (MPFS) Final Rule and announces the Telehealth Originating Site Facility Fee payment amount. The attached recurring update notification applies to publication 100-04, chapter 12, section 190.5, chapter 13, section 20.2.4, and chapter 18, section 240.

EFFECTIVE DATE: January 1, 2021

**Unless otherwise specified, the effective date is the date of service.*

IMPLEMENTATION DATE: January 4, 2021

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)

R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	

III. FUNDING:

For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to provide a summary of the policies in the CY 2021 Medicare Physician Fee Schedule (MPFS). 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. The Centers for Medicare & Medicaid Services (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.

B. Policy: This CR provides a summary of the payment policies under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2021

CMS issued regulation number CMS-1734-F, Medicare Program: Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2021. This CR provides a summary of the payment policies under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2021.

Medicare Telehealth Services

For CY 2021, CMS is finalizing the proposal to add several Healthcare Common Procedure Coding System (HCPCS) codes to the list of telehealth services on a permanent basis. CMS is also finalizing the proposal to add additional HCPCS codes to the list of telehealth services on a temporary basis until the end of the calendar year in which the Public Health Emergency (PHE) for the Severe Acute Respiratory Syndrome Coronavirus 2 (SARS-CoV-2) or COVID-19 ends or December 31, 2021. The list of codes that are added to the telehealth services list can be found 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 calendar year, the telehealth originating site facility fee is increased 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%. Therefore, for CY 2021, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or \$27.02 (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

For more information regarding Telehealth Services, contact Emily Yoder (410) 786-1804

Remote Physiologic Monitoring (RPM)

In response to stakeholder questions about RPM, CMS clarified in the CY 2021 MPFS final rule payment policies related to the RPM services described by Current Procedural Terminology (CPT) codes 99453, 99454, 99091, 99457, and 99458. In addition, CMS 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 consent to be obtained at the time that RPM services are furnished and allowing auxiliary personnel to furnish CPT codes 99453 and 99454 services under a physician's supervision. Specific clarifications related to payment policies can be found in the Care Management section of the MPFS final rule.

Item for Regulatory Action Regarding Scope of Practice:

Supervision of Diagnostic Tests

For CY 2021, CMS is finalizing the proposed policy regarding supervision of diagnostic tests by certain Nonphysician 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. Accordingly, 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. Additionally, these NPPs must meet the supervision requirements under Medicare regulations that govern their respective statutory benefit category.

For more information regarding supervision of diagnostic tests, please contact Roberta Epps at (410) 786-4503 or, Regina Walker-Wren at (410) 786-9160

Medical Record Documentation:

In the CY 2020 PFS final rule, CMS finalized broad modifications to the medical record documentation requirements for the physician and certain NPPs. In the CY 2021 PFS final rule, CMS clarified 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 PFS. CMS also clarified that 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.

For more information regarding Medical Record Documentation, contact Sarah Leipnik 410-786-3933

Therapy Assistants Furnishing Maintenance Therapy

For CY 2021, CMS is 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). This Part B policy allows PTs/OTs to use the same discretion to delegate maintenance therapy services to PTAs/OTAs that they utilize for rehabilitative services.

For more information regarding Maintenance Therapy, contact Gift Tee 410-786-9316

Pharmacists Providing Services Incident To Physicians' Services

For CY 2021, CMS is 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 § 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 is not 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 cannot use 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.

For more information regarding Pharmacists Providing Services Incident To Physicians' Services, contact Ann Marshall 410-786-3059

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), CMS is finalizing the proposal to permanently implement the policy, for CY2021, 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. In addition, for residency training sites of a teaching setting that are outside of an MSA, CMS is 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. Finally, 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 evaluation and management visit, transitional care management, and communication technology-based services.

These flexibilities do not apply in the case of surgical, high-risk, interventional, or other complex procedures; services performed through an endoscope and anesthesia services. Further, in order to ensure that the teaching physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which the payment is sought, in accordance with section 1842(b)(7)(A)(i)(I) of the Act, the full documentation in the medical record must clearly reflect how the teaching physician was present to the resident during the key portion of the service. For example, in the medical record, the teaching physician could document their physical or virtual presence during the key portion of the service.

For more information regarding teaching physician regulations, please contact Christiane Labonte at 410-786-7237 or Cindy Bergin at 410-786-1176.

Resident Moonlighting

In the 2021 NPRM, CMS solicited 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. CMS is finalizing the proposal to permanently expand the settings in which residents may moonlight to include the services of residents that are not 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. In order 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 providers in § 415.102(a), that the resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed, and that the services are not performed as part of the approved GME program.

For more information regarding resident moonlighting, please contact Christiane Labonte at 410-786-7237 or Cindy Bergin at 410-786-1176.

Office/Outpatient Evaluation & Management Visits

Effective January 1, 2021, CMS is implementing new coding, prefatory language, and interpretive guidance framework that has been issued by the American Medical Association Current Procedural Terminology Editorial Panel for office/outpatient Evaluation and Management (E/M) visits. For further guidance, please see: <https://www.ama-assn.org/practice-management/cpt/cpt-evaluation-and-management>. 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 more information regarding office/outpatient evaluation and management visits, contact Ann Marshall at 410-786-3059, Christiane LaBonte at 410-786-7237, Emily Yoder at 410-786-1804, or Liane Grayson at 410-786-6583.

Prolonged Office/Outpatient E/M Visits

Effective January 1, 2021, CMS is finalizing HCPCS code G2212 for prolonged office/outpatient E/M visits. HCPCS code 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 attached document titled: Prolonged Office Outpatient Evaluation and Management Reporting Times. The tables displayed within the document delineate required times for reporting prolonged office/outpatient E/M visits. When the time of the reporting practitioner 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.

For more information regarding prolonged office/outpatient evaluation and management visits, contact Ann Marshall at 410-786-3059 or Christiane LaBonte at 410-786-7237.

Office/Outpatient E/M Visit Complexity Add-On

Starting in 2021, there will be a new, Medicare-specific add-on code to report office/outpatient E/M visit complexity. It is HCPCS code 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 services to patients on an ongoing basis 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 PE associated with providing services that result in care that is personalized to the patient. We are not restricting billing based on specialty, but do assume that certain specialties furnish these types of visits more than others.

For more information regarding the office/outpatient E/M visit complexity Add-on, please contact Ann Marshall at 410-786-3059

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

For CY 2021, CMS is 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. CMS is also finalizing 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, CMS is 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. CMS is finalizing 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. Additionally, CMS is finalizing the proposal to allow periodic assessments to be furnished via two-way interactive audio-video communication technology.

For more information regarding Opioid Use Disorder Treatment furnished by Opioid Treatment Programs, contact Lindsey Baldwin 410-786-1694 or Terry Simananda 410-786-8144.

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), CMS 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 PFS for use of esketamine in services to patients with treatment-resistant depression. After consideration of public comments, for CY 2021, CMS is 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.

For more information regarding esketamine, contact Terry Simananda 410-786-8144

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), CMS 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, CMS is 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.

For more information regarding implantable interstitial glucose sensor, contact Terry Simananda 410-786-8144

CT Modifier Reduction List

Effective January 1, 2021, CMS is adding HCPCS code 71271 (*Computed tomography, thorax, low dose for lung cancer screening, without contrast material(s)*) to the list of codes contained within Change Request (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 Medicare Change Request number 9250 effective January 1, 2016.

For more information regarding the CT Modifier Reduction List, please contact Patrick Sartini at 410-786-9252

CPT Codes that CMS Finalized as Contractor Priced

Remote Retinal Imaging (CPT code 92229)

CMS is 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 RUC recommended a \$25 "per click" analysis fee for remote imaging that is conducted by AI software. As our practice expense (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 are not 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 Calendar Year (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 is not 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, artificial intelligence, or other new forms of analysis to determine a course of treatment, where the analysis portion of the service cannot adequately be reflected under the PFS 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 PFS payment methodology. Our recent reviews

Number	Requirement	Responsibility									
		A/B MAC		D M E	Shared- System Maintainers				Other		
		A	B		H H H	M A C	F I S S	M C S		V M S	C W F
	Preventive-Services.html.										

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility						
		A/B MAC			D M E	C E D I		
		A	B	H H H				
12071.6	MLN Article: CMS will make available an MLN Matters provider education article that will be marketed through the MLN Connects weekly newsletter shortly after the CR is released. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1, instructions for distributing MLN Connects information to providers, posting the article or a direct link to the article on your website, and including the article or a direct link to the article in your bulletin or newsletter. You may supplement MLN Matters articles with localized information benefiting your provider community in billing and administering the Medicare program correctly. Subscribe to the “MLN Matters” listserv to get article release notifications, or review them in the MLN Connects weekly newsletter.	X	X	X				

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kathleen Kersell, 410 786-2033 or Kathleen.Kersell@cms.hhs.gov , Julie Adams, 410-786-8932 or julie.adams@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):

The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

ATTACHMENTS: 1

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 and 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 and including prolonged time, spent by the reporting practitioner on the date of service of the visit.