CY 2021 Medicare Physician Fee Schedule Final Rule (CMS-1734-F)

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INTRODUCTORY SUMMARY AND BACKGROUND

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

Since 1992, Medicare has paid for physician services under section 1848 of the Social Security Act entitled "Payment for Physicians' Services." This statute requires CMS to establish payments under the physician fee schedule (PFS) based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service.

The statute requires that RVUs be established for three categories of resources:

- Work **(Work)** – services the physician provides.
- Practice Expense **(PE)** – resources that are used to provide physician services, such as office overhead and staff salaries.
- Malpractice **(MP)** expense – costs involved in malpractice insurance.

In addition, the statute requires CMS establish by regulation each year's payment amounts for all physicians' services paid under the PFS, incorporating geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas. This is referred to as the geographic practice cost indices **(GPCIs)**.

RVUs are converted to dollar amounts through the application of the conversion factor **(CF)**. The formula for the calculating the MPFS is as follows:

Payment = [(RVU work x GPCI work) + (RVU PE x GPCI PE) + (RVU MP x GPCI MP)] x CF

MPFS Final Rule

The CY 2021 final rule is located in its entirety at the following link:
https://www.cms.gov/files/document/12120-pfs-final-rule.pdf.

This document in PDF form is 2,165 pages in length. The format of the information is intended to summarize the finalized changes so readers are encouraged to view the document in its entirety for further details.

FINALIZED CHANGES TO MPFS PAYMENT RATES

Conversion Factor (CF)

Section 1848 of the Act requires CMS to maintain the budget within $20 million annually. In the event it is projected to exceed this amount, budget neutrality adjustments are made. In the CY 2021 final rule, CMS is applying a minus 10.20 percent adjustment, which is a decrease from the proposed rule adjustment of minus 10.61 percent resulting in a CF of $32.4085. Table 104 from the final rule outlines the calculation:

TABLE 104: Calculation of the CY 2021 PFS Conversion Factor

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

To calculate the CY 2021 CF, the product of the current year CF and the update adjustment factor was multiplied by the budget neutrality adjustment. As part of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the CF was frozen at CY 2020 value with no increase for the next five years. The CY 2020 CF is $36.0896 and this value is used for CY 2021 with direct adjustment.

Changes in RVUs

The significant CF decrease does not impact all specialties equally. Impacts to the CF are related to changes associated to misvalued codes; phasing in the Direct Practice Expense equipment value changes; and increases in valuation for evaluation and management (E/M) services. The most widespread impacts for CY 2021 are the misvalued codes, including RVUs for new and revised codes.

Table 106 outlines the combined payment impact per specialties including cardiac surgery, interventional radiology and vascular surgery pertaining to the RUV changes for CY 2021. The actual impact on total Medicare revenues will be different from those shown in this table. Allowed charges are the PFS amounts for covered services and include coinsurance and deductibles (which are the financial responsibility of the beneficiary). These amounts have been summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty:

TABLE 106: CY 2021 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F)* Combined Impact
Cardiac Surgery	$266	-5%	-2%	0%	-8%
Interventional Radiology	$499	-3%	-5%	0%	-8%
Vascular Surgery	$1,293	-2%	-4%	0%	-6%

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

To account for increases impacting some specialties, monies must be reallocated from other specialties to cover and maintain budget neutrality. The estimated impacts for other specialties including cardiac surgery reflect decreased payments as a result of relative payments to other physician specialties, such as endocrinology, rheumatology, family practice and hematology/oncology. These specialties will see increases. These estimations also reflect implementation of finalized updates to supply and equipment pricing; and indirect practice expense (PE) allocations for some office-based services.

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

Work RVUs

Work RVUs are established for new, revised and potentially misvalued codes based on the portion of resources used in furnishing the service that reflects physician time and intensity. The impacts for CY 2021 are reflected in column C of the above table.

Practice Expense RVUs (PE)

PE RVUs are developed by reviewing practice resources involved in providing each service and are comprised of direct and indirect PE. For direct PE (clinical staff, medical supplies, medical equipment), these costs are calculated based on inputs from the CMS PE database, generally centered on recommendations of the Relative Value Scale Update Committee (RUC). Indirect PE costs are developed primarily on the Physician Practice Expense Information Survey (PPIS). Implemented in CY 2010, the PPIS is a multispecialty, nationally representative, PE survey of both physicians and NPPs paid under the PFS. The impacts for CY 2021 are reflected in column D of the above table.

For procedures provided in a physician's office or facility setting in which Medicare makes a separate payment to the facility, CMS establishes 2 PE RVUs: facility and nonfacility. In calculating PE RUVs for physician services provided in a facility, resources not typically utilized by physicians while providing services are excluded. Thus, facility PE RVUs are typically lower than nonfacility PE RUVs.

Diagnostic services are generally comprised of a professional component (PC); and a technical component (TC). The PC and TC may be furnished independently, by different providers, or together as a global service. Each component has separate reimbursement; however, payment for the global service equals the sum of the payment for TC and PC. This is based on a weighted average of the ratio of direct to indirect costs across all specialties that provide the global service.

Malpractice RVUs (MP)

MP RVUs are considered to be resourced based and required to be reviewed annually to more accurately represent and evaluate the mix of practitioners providing services on Medicare claims. There are three factors which are considered to determine MP RVUs for PFS services:

1) Specialty-level risk factors derived from data on specialty-specific MP premiums incurred by practitioners;

2) Service-level risk factors derived from Medicare claims data of the weighted average risk factors of the specialties that furnish each service; and
3) Intensity/complexity of service adjustment to the service level risk factor based on either the higher of the work RVU or clinical labor RVU.

Prior to CY 2016, MP RVUs were updated every 5 years unless there were new or revised codes introduced. MP GPCI is currently reviewed every three years. The CY 2016 MPFS final rule implemented the policy to review MP RVUs annually. The new policy also specifies use of 3 years' worth of data rather than 1 year.

For CY 2020, CMS finalized their proposal that the values of the MP RVUs and MP GPCI be coordinated because the MP premium data used to update the MP GPCI is the same to determine the risk levels of the specialties. This change would put the next review for implementation in CY 2023. The impacts for CY 2021 are reflected in column E of the above table.

Geographic Practice Cost Indices (GPCIs)

CMS is required to develop separate GPCIs to measure cost differences among localities compared to the national average. CMS adjusts reimbursement to align with the cost of those services specific to where they were provided. This is done by applying the GPCI values for a specific area to each of the RVUs (work, practice expense, and malpractice). This is one of the reasons when discussing reimbursement, it is not always an apples-to-apples comparison with regard to how much is reimbursed from one location to another.

The current fee schedule areas are referred to as payment localities and are defined by state boundaries; metropolitan areas; portions of a metropolitan area; or rest-of state areas. There are currently 112 payment localities. This locality configuration is used to calculate GPCIs, that in turn, are used to calculate locality adjusted payment for physicians under PFS.

Five states are defined as "frontier states" by CMS: Montana, Wyoming, North Dakota, South Dakota and Nevada. A frontier state is one in which at least 50 percent of the counties are "frontier counties" (counties that have a population per square mile of less than 6). This is significant because the cost of living can be relative to how populated an area might be. Thus, a less populated area could have less services and lower reimbursement. These frontier states have a PE GPCI floor of 1.000, effective CY 2011.

For CY 2021, there are no updates for GPCIs. CMS refers to updates for CY 2020 as the latest updates for GPCIs.

Valuation of Specific Codes for CY 2021

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

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

Complete Transthoracic Echocardiography (TEE) with Doppler (CPT® code 93306)

CPT® code 93306 *(Echocardiography, transthoracic, real-time with image documentation (2D), includes M-mode recording, when performed, complete, with spectral Doppler echocardiography, and with color flow Doppler echocardiography)* was nominated by a submitter for potential misvaluation in CY 2019. This was based on

information provided by the Government Accountability Office (GAO), Medicare Payment Advisory Commission (MedPAC) and Urban Institute reports which suggested the work RVUs were overstated. Specialty societies and the RUC stated there was a change in technique and technology to perform the procedure, so the code was resurveyed and a new work RVU was proposed. After comments received on this procedure, CMS finalized the proposed work RVUs.

Additionally, CMS proposed and finalized the RUC-recommended direct PE RVUs without refinement for this code.

Intracardiac Echocardiography (ICE) (CPT®® code 93662)

CPT® code +93662 *(Intracardiac echocardiography during therapeutic/diagnostic intervention, including imaging supervision and interpretation (List separately in addition to code for primary procedure)* was identified with the utilization screen of over 10,000 claims in a year. This procedure has changed since its last review in terms of reduced use of fluoroscopy and increased use of ultrasound to create 3-dimentional electroanatomical maps. CMS did not agree with the RUC-recommended work RVUs and after comments received, CMS finalized the proposed work RVUs.

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

The CPT® Editorial Panel released CPT® code 99072 *(Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other nonfacility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease)* after the release of the MPFS proposed rules. During the comment period stakeholders reached out to CMS for immediate consideration of valuation of code 99072 due to the expenditures incurred by providers in response to COVID-19. Requests were for valuation of direct PE inputs for the supplies and clinical staff time beyond the services in which it may be provided.

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

Evaluation and Management (E/M) Guidelines

Evaluation and Management (E/M) visits comprise nearly 40 percent of allowed charges for Physician Fee Schedule (PFS) services, and office/outpatient E/M visits make up nearly 20 percent of the allowed PFS charges. Nearly all specialties utilize and bill for E/M visits, for some this comprises the bulk of their charges. For other specialties that are more procedural based, the bulk of services billed are not E/M. Due to the volume of E/M visits billed each year and the fact the guidelines had not been updated since 1995 and 1997, CMS and the AMA have been working to revamp the outpatient new and established patient visits.

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

Visit Complexity (HCPCS code G2211)

In the MPFS final rule, CMS followed through on a new HCPCS code for complex services. However, instead of accepting the CPT® code for prolonged services, CMS created a new HCPCS code for this service.

CMS finalized a new code to account for complexity of services provided to new and established patients. CMS indicated they believe the updated definitions for CPT® 99202-99215 reflect the work provided in a "typical" office outpatient visit; however, for some specialties they do not adequately capture the resources associated with patient care. Therefore, CMS finalized add-on HCPCS code +G2211, previously represented by temporary code GPC1X:

Code	Description
+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 (List separately in addition to office/outpatient evaluation and management visit, new or established)

This code is for use by any specialty for the ongoing care needs of the patient and potentially evolving illness.

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

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

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

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

Prolonged Services (HCPCS code G2212)

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

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

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

To remedy the discrepancies in reporting for prolonged services with office/outpatient visits, CMS created the HCPCS add-on code **+G2212**:

Code	Description
+G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (List separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services)

In addition, CMS states, *"(Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes))."*

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

CPT®	Description	2020 Final Payment Rate	2021 Final Payment Rate	Variance	% Change
99202	Office o/p new sf 15-29 min	$ 77.23	$ 69.03	$ (8.20)	-10.6%
99203	Office o/p new low 30-44 min	$ 109.35	$ 106.30	$ (3.05)	-2.8%
99204	Office o/p new mod 45-59 min	$ 167.09	$ 159.77	$ (7.32)	-4.4%
99205	Office o/p new hi 60-74 min	$ 211.12	$ 210.98	$ (0.14)	-0.1%

99211	Office o/p est minimal prob	$	23.46	$	22.04	$	(1.42)	-6.1%
99212	Office o/p est sf 10-19 min	$	46.19	$	54.12	$	7.93	17.2%
99213	Office o/p est low 20-29 min	$	76.15	$	86.85	$	10.71	14.1%
99214	Office o/p est mod 30-39 min	$	110.43	$	123.48	$	13.04	11.8%
99215	Office o/p est hi 40-54 min	$	148.33	$	172.74	$	24.41	16.5%

Telehealth Services After the End of the Public Health Emergency

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

Due to the uncertainty of how long the public health emergency (PHE) will last, and effects of COVID-19 for patients in terms of comfort level, CMS has finalized a phased-in end to the waivers and expansions for some items rather than an abrupt stop.

Specifically, CMS proposed and finalized several changes to telehealth services moving forward. Any new services added to the Category 3 level of telehealth services as part of the final rule, will remain on the Medicare telehealth services list through the calendar year in which the PHE for COVID-19 ends. Other services which were added as part of the waivers, will no longer be allowed as telehealth services once the PHE ends.

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

TABLE 16: Summary of CY 2021 Services Added to the Medicare Telehealth Services List	
Type of Service	**Specific Services and CPT Codes**
1. Services we are finalizing for permanent addition as Medicare Telehealth Services	• Group Psychotherapy (CPT 90853) • Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99334-99335) • Home Visits, Established Patient (CPT 99347- 99348) • Cognitive Assessment and Care Planning Services (CPT 99483) • Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS G2211) • Prolonged Services (HCPCS G2212) • Psychological and Neuropsychological Testing (CPT 96121)
2. Services we are finalizing to remain temporarily on the Medicare telehealth list through the end of the year in which the PHE for COVID-19 ends (Category 3 services), to allow for continued development of evidence to demonstrate clinical benefit and facilitate post-PHE care transitions.	• Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337) • Home Visits, Established Patient (CPT 99349-99350) • Emergency Department Visits, Levels 1-5 (CPT 99281-99285)* • Nursing facilities discharge day management (CPT 99315-99316) • Psychological and Neuropsychological Testing (CPT 96130- 96133; CPT 96136-96139) • Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161-97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521-92524, 92507)* • and Hospital discharge day management (CPT 99238- 99239)*

	• Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT 99469, 99472, 99476)* • Continuing Neonatal Intensive Care Services (CPT 99478- 99480)* • Critical Care Services (CPT 99291-99292)* • End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962)* • Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224- 99226)*
3. Services we are not adding to the Medicare telehealth list either permanently or temporarily.	• Initial Nursing Facility Visits, All Levels (Low, Moderate, and High Complexity) (CPT 99304-99306) • Initial hospital care (CPT 99221-99223) • Radiation Treatment Management Services (CPT 77427) • Domiciliary, Rest Home, or Custodial Care services, New (CPT 99324- 99328) • Home Visits, New Patient, all levels (CPT 99341- 99345) • Inpatient Neonatal and Pediatric Critical Care, Initial (CPT 99468, 99471, 99475, 99477) • Initial Neonatal Intensive Care Services (CPT 99477) • Initial Observation and Observation Discharge Day Management (CPT 99218 – 99220; CPT 99234- 99236) • Medical Nutrition Therapy (CPT G0271)

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

Telehealth Services Technology Requirements

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

Audio-only Visits

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

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

On an interim basis, CMS has created a HCPCS code for extended audio-only assessment service. This has been designed for those patients, who even after the PHE has ended, are still reluctant to return for in-person visits to their practitioner. This will also allow CMS to determine if this code should be made permanent. Effective for CY 2021 HCPCS code G2252 is available for use and was cross walked to code 99442 for valuation:

Code	Description
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)

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

Physician Supervision for Telehealth Services

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

CMS has finalized to extend direct supervision expansion under MPFS to end later in the calendar year in which the PHE ends or December 31, 2021. This will allow, along with other waivers and extensions, an easement to the change in supervision than an immediate end of the PHE, allowing physicians and practices to prepare for the change back to the in-person requirement.
CMS did clarify, the use of real-time audio and video technology to provide direct supervision under MPFS does not mean the physician must be actively observing and using the technology throughout the entire procedure. Instead, the supervising physician is immediately available to engage via the real-time audio and video technology (excluding audio-only) throughout the procedure.

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

Physician Supervision of Physician Assistant (PA) Services

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

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

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

CMS has finalized to allow NPs, CNSs, PAs or CNMs to supervise diagnostic tests on a permanent basis as allowed by state law and scope of practice. CMS also finalized diagnostic tests performed by a PA in accordance with their scope of practice and state law, which do not require the specified level of supervision assigned to individual tests. This is because the relationship of PAs with physicians would continue to apply.

Stay tuned for additional updates and changes for CY 2021.