

Physician and Freestanding Facilities Update

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On Nov. 2, 2021, CMS issued a final rule for the Medicare Physician Fee Schedule (MPFS) for CY 2022. The MPFS Final Rule can be accessed online at: [federalregister.gov/public-inspection/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part](https://www.federalregister.gov/public-inspection/2021-23972/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part). This rule applies to all physicians and office-based cancer programs and practices. Even if a physician is employed by—or works in—a hospital, their payment rules are governed by the MPFS.

MPFS Payment Rates

For CY 2022, CMS does not have the authority to reverse and apply the 3.75 percent increase outlined as part of the Consolidated Appropriations Act of 2021, which adjusted the finalized conversion factor (CF) for 2021. Due to this, for CY 2022, CMS had to use the finalized 2021 CF –3.75 percent, resulting in a base start for CY 2022 of \$33.6319, rather than \$34.8931. The

agency had originally proposed a budget neutrality adjustment of –0.14 percent, but after adjustments in the MPFS final rule, this percentage was reduced to –0.10 percent, resulting in a finalized CY 2022 CF of \$33.5983. Table 1, below, outlines these elements that impact the conversion factor.

The CF reduction results in decreases for many specialties and their estimated impacts; however, CMS also applied additional decreases to many of the practice expense (PE) values, which create a deeper cut to specialties, such as interventional radiology, radiation oncology, vascular surgery, and cardiology. The negative impacts are specifically related to the PE values for equipment and clinical labor and reflect changes that take place within the pool of total RVUs. The changes for CY 2022 per CMS “*result from finalized policies within BN [budget neutrality] (such as the revaluation of E/M [evaluation and management] codes in CY 2021 or the clinical labor pricing update in CY 2022) but*

does not include any changes in spending which result from finalized policies outside of BN.”

Estimated impacts for select specialties are as follows:

- Radiation oncology will see a –1 percent reduction (proposed to be –5 percent reduction).
- Hematology/Oncology will see a –1 percent (proposed to be –2 percent reduction).

Table 2, page 2, outlines the combined impact per specialty, including interventional pain management, interventional radiology, radiology, radiation oncology, and hematology/oncology, regarding RVU changes for CY 2022.

Clinical Labor

Clinical labor rates were last updated in CY 2002, and CMS proposed to update the values for CY 2022 using CY 2019 survey data from the Bureau of Labor and Statistics (BLS) and other supplementary data when BLS

Table 1. Calculation of the CY 2022 MPFS Conversion Factor

CY 2021 conversion factor	\$34.8931
Conversion factor without CY 2021 Consolidated Appropriations Act provision	\$33.6319
Statutory update factor	0.00 percent (1.0000)
CY 2022 RVU budget neutrality adjustment	–0.10 percent (0.9990)
CY 2022 conversion factor	\$33.5983

RVU = relative value unit

Table 2. RO Model National Base Rates

SPECIALTY	ALLOWED CHARGES (MILLIONS)	IMPACT OF WORK RVU CHANGES	IMPACT OF PE RVU CHANGES	IMPACT OF MP RVU CHANGES	COMBINED IMPACT
Radiation oncology and radiation therapy centers	\$1,605	0%	-1%	0%	-1%
Hematology/oncology	\$1,679	0%	-1%	0%	-1%
Interventional pain management	\$865	0%	2%	0%	1%
Interventional radiology	\$465	0%	-5%	0%	-5%
Radiology	\$4,257	0%	-1%	0%	-1%

PE = practice expense; RVU = relative value unit

data are not available. Note: an increase in labor values is indicated for all labor types reviewed by CMS; however, many of the finalized values decreased from what was proposed due to a decrease in the value of fringe benefits factor, proposed at 1.366 and finalized at 1.296. Because values are maintained in a budget-neutral manner, an increase for one specialty or one code (or code set) is possible only because it was taken or adjusted from another specialty or code (or code set). For some specialties, like family practice, labor has a higher than average share of the direct costs, whereas in other specialties, like radiation oncology, labor has a lower than average share of the direct costs. Accordingly, specialties with the higher share of labor costs are proposed to receive increased payments for their services, whereas specialties that have lower direct costs associated to clinical labor will see decreases in payment for their services. After considerable pushback, CMS finalized the adoption of a 4-year phase-in. When split over 4 years, the clinical labor adjustment still negatively impacts interventional radiology services, but each year has a smaller adjustment than if total cuts were applied at one time.

CMS also moved forward with several revisions to the clinical labor pricing values for a variety of clinical labor types. For

example, stakeholder feedback disagreed with the CMS crosswalk for medical dosimetrist to 19-1040 (medical scientists) at an hourly rate of \$46.95. It was suggested to instead use BLS category 29-2098 (medical dosimetrists, medical records specialists, and health technologists and technicians, all other). CMS did not agree with this suggestion, because the median wage is \$20.50, and data from SalaryExpert (salaryexpert.com) supports an hourly rate of \$48.31. The inclusion of medical dosimetrist in the title is misleading because it is an aggregate of several types of miscellaneous technicians, and if the suggested rate were used, the hourly rate would be less than the 2002 value.

Commenters also disagreed with use of the 75th percentile for medical physicists, because this maintains the current values and suggests that the physicist category would be the most appropriate to use. Again, CMS did not agree with this suggestion, because the median hourly wage is \$59.06 for physicists in the BLS category compared SalaryExpert’s medical physicist median hourly wage of \$66.90. Data from the American Association of Physicists in Medicine (AAPM) 2020 Professional Survey provide a rate of \$2.25/minute. CMS believes that these data are more representative with adjustment and therefore proposed a fringe

benefits multiplier value of \$2.14/minute for medical physicists. Table 3, page 3, highlights the finalized clinical labor pricing values that impact oncology. Table 4, page 3, illustrates the impact these clinical labor pricing changes will have by select specialties.

Addressing Changes to E/M Services

CMS indicated that when the AMA adopted the new guidelines for outpatient and office setting E/M visits, CMS also adopted the changes. In the months since implementation, CMS indicated that there was a need for clarification or adjustment to previous guidelines to align all guidance more fully with the updates. To do this, CMS specifically addressed a few areas:

- Split (or shared) visits
- New and established patients and initial and subsequent visits
- Payment for the services of teaching physicians.

Split (or Shared) Visits

Per CMS, the guidelines do not address:

- Who to bill under when the visit is performed by different practitioners.
- Whether a substantive portion must be performed by the billing practitioner.
- Whether practitioners must be in the same group.

Table 3. Finalized 2022 Clinical Labor Pricing Updates Impacting Oncology

LABOR CODE	LABOR DESCRIPTION	SOURCE	CURRENT RATE PER MINUTE	UPDATED RATE PER MINUTE	Y1 PHASE-IN RATE PER MINUTE	TOTAL % CHANGE
L050C	Radiation therapist	BLS 29-1124	0.50	0.89	0.60	78%
L050D	Second radiation therapist for IMRT	BLS 29-1124	0.50	0.89	0.60	78%
L063A	Medical dosimetrist	BLS 19-1040	0.63	0.91	0.70	44%
L107A	Medical dosimetrist/ medical physicist	L063A, L152A	1.08	1.52	1.19	41%
L152A	Medical physicist	AAPM Data*	1.52	2.14	1.68	41%
L056A	RN/OCN*	BLS 29-2033	0.79	0.81	0.80	3%
L050B	Diagnostic medical sonographer	BLS 29-2032	0.50	0.77	0.57	54%
L051B	RN/diagnostic medical sonographer	L051A, BLS 29-2032	0.51	0.77	0.58	51%

*Updated in response to comments. OCN = oncology certified nurse; RN = registered nurse.

Table 4. Anticipated Clinical Labor Pricing Effect on Specialty Impacts

SPECIALTY	ALLOWED CHARGES (MILLIONS)	FULLY UPDATED	Y1 PHASE-IN TRANS
Hematology/oncology	\$1742	-2%	-1%
Radiation oncology and radiation therapy centers	\$1666	-3%	-1%
Interventional pain management	\$897	-1%	0%
Radiology	\$4417	-1%	0%
Vascular surgery	\$1149	-5%	-1%
Interventional radiology	\$482	-6%	-2%
Diagnostic testing facility	\$689	-7%	-2%

Note: CMS isolated the anticipated impacts that labor value changes would have on the various specialties and the payment for their services. The agency emphasized that the values in this table from the MPFS Final Rule are not the projected impacts by specialty of all policies finalized for CY 2022; the values only represent the anticipated effect of the isolated clinical labor pricing update. Therefore, the allowed changes for each specialty may not match the allowed charges listed in the “Regulatory Impacts Analysis” section of the rule.

- The setting where the split (or shared) visits may be furnished to be billed.

Within the 2021 CPT® E/M guidelines, the AMA states that “a split or shared visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physicians and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for split or shared visits (that is, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted).”

CMS proposed and finalized defining a split (or shared) visit as an E/M visit performed (split or shared) by both a physician and non-physician practitioner (NPP) who are in the same group in accordance with applicable laws and regulations for new and established patient visits. The visit is provided in a facility setting in which payment for services furnished incident to is prohibited. In the non-facility setting, when the physician and NPP each perform components of the visit, the visit can be billed under the physician if incident-to

criteria are met. The services are provided in accordance with applicable laws and regulations, specifically either the physician or NPP could bill the payer directly for the visit in the facility setting, rather than bill as a split (or shared) visit. CMS also proposed and finalized allowing for split (or shared) visits to be billed for both new and established E/M patient visits. CMS clarified that only the physician or NPP who performs the substantive portion of the split (or shared) visit bills for the visit. CMS is defining “substantive portion” to mean more than half of the total time spent by the physician or NPP performing the visit.

CMS did make an adjustment to its proposal. CY 2022 will be a transitional year, except for critical care visits, and the substantive portion will be defined by one of three key components (history, exam, and medical decision making [MDM]) or more than half of the total time spent by the physician and NPP performing the split (or shared) visit and require a yet defined modifier when billed on a claim. Table 5, below, outlines the differences between CY 2022 and CY 2023 in the MPFS Final Rule as they relate to the definition of “substantive portion” of a visit.

Due to the need to determine the amount of time spent by each entity, CMS recommended documenting the time spent in the note, even if the MDM method is selected to

code the visit. In addition, the entity who performs the substantive portion of the visit is the one to sign and date the note, but documentation should include the names and credentials of both entities.

CMS finalized that the time between the physician and NPP be totaled and the one with more than half of the time will bill the visit based on the total time documented. The agency also finalized that the substantive portion could include time with or without direct patient contact. One of the practitioners performing the visit must have face-to-face (in-person) contact with the patient, but it does not have to be the practitioner who performs the substantive portion and bills for the visit.

CMS proposed and finalized that prolonged services could be billed in addition to a visit when the time-based method is used for billing. This would only apply for other outpatient and inpatient/observation/hospital/nursing facilities; use of prolonged services would *not* apply to emergency department and critical care visits.

CMS outlined a list of services that count toward the total time for determining the substantive portion. Activities include:

- Preparing to see the patient (e.g., review of tests)
- Obtaining and/or reviewing separately captured history
- Performing a medically appropriate examination and/or evaluation

Table 5. Final Definition of Substantive Portion for E/M Visit Code Families

E/M VISIT CODE FAMILY	2022 DEFINITION OF SUBSTANTIVE PORTION	2023 DEFINITION OF SUBSTANTIVE PORTION
Other outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/observation/hospital/nursing facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical care	More than half of total time	More than half of total time

*Office visits will not be billable as split (or shared) services. MDM = medical decision making.

- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other healthcare professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported)
- Communicating results to the patient/family/caregiver
- Providing care coordination (not separately reported).

The agency also identified services and items that do not count toward time spent in the visit:

- Performance of other services that are reported separately
- Travel
- Teaching that is general and not limited to discussion that is required for the management of a specific patient.

If the physician and NPP are not in the same group, each would be expected to bill independently based on the full E/M criteria for the work provided. If neither clinician meets the criteria to bill a visit, modifier 52 for reduced services cannot be applied to the E/M visit codes. In this scenario, the visit is not billable for either entity.

Payment for the Services of Teaching Physicians

Stakeholders requested guidance on how time spent by the resident should be counted when selecting the appropriate E/M office visit level. Section 1842(b) of the Act specifies that *“in the case of physicians’ services furnished to a patient in a hospital with a teaching program, the secretary shall not provide payment for such services unless the physician renders sufficient personal and identifiable physicians’ services to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought.”*

CMS proposed and finalized that when total time is used to determine the appropriate E/M office visit level, only the time that the teaching physician was present can be

included. Because Medicare already makes payment for the program’s share of the resident’s involvement, CMS does not feel it would be appropriate to count the resident’s time toward the total time and only that of the teaching physician would count.

Telehealth Services

CMS received several requests from stakeholders to permanently add several services to the Medicare telehealth services list effective for CY 2022. None of the requests received by the imposed deadline met the category 1 or category 2 criteria to be added permanently.

In response to the COVID-19 public health emergency (PHE), CMS created a category 3 for temporarily added services to the telehealth list. To be permanently added to the list, the services would need to meet category 1 or category 2 criteria; otherwise, services would only be on the list under category 3 for a temporary basis.

CMS proposed and finalized maintaining a category 3 for telehealth services through CY 2023 to allow for the collection of data regarding utilization to better determine whether the temporary designated codes actually meet the criteria to be permanently added. There are a series of codes that CMS only added to the list of telehealth services for the duration of the PHE, and these have not been extended to temporary category 3 status. These services will be removed from telehealth when the PHE ends. As of right now, the PHE is scheduled to end Jan. 16, 2022. CMS solicited comments as to whether any of the services added for the duration of the PHE should be added to the Medicare telehealth list on a category 3 basis to allow for the collection of data to consider permanent addition to the list.

CMS did extend its plan to maintain many of the waivers and extensions related to telehealth for mental health conditions once the PHE ends. Services for diagnoses not related to mental health conditions will begin to end in accordance with their initial application. Temporary services that were added as category 3 codes will remain available on the list until the end of CY 2023 per CMS.

Communication-Based Technology

CMS will remove the audio-only visit codes (CPT **99441-99443**) from the list of approved telehealth services for all services except those related to mental health services. At the initiation of the PHE, CMS noted there was a significant increase in telehealth services, but these telehealth services dropped off for all specialties except for mental health services.

CMS proposed and finalized permanently adopting coding and payment for HCPCS code **G2252**, one of the communication-based services recognized by CMS as billable by physicians or qualified healthcare professionals for a brief check-in lasting 11 to 20 minutes. Originally, this service was created to be used on an interim basis. After stakeholder feedback identified the need for a communication service longer than 10 minutes, CMS finalized code **G2252** as permanent with an assigned payment.

Physician Supervision of Therapeutic Services

CMS sought feedback on the flexibilities extended during the PHE related to physician supervision. The agency also sought comments on whether additional time is needed beyond the conclusion of the PHE before returning to the standard application of direct supervision. Outside the PHE, direct supervision in the office setting is the requirement. This *“requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service, and we have interpreted this as ‘immediate availability.’”* Through PHE waivers and extensions, CMS continued the requirement of direct supervision but allowed this to be performed through real-time audio and/or video capabilities. CMS sought comments as to whether direct supervision in the office setting should be permanently allowed by real-time audio and/or video capabilities for only a subset of services and whether a service-level modifier should be created to identify when the requirements for direct supervision were met using real-time audio and/or video capability if extended. After receipt of comments, CMS

indicated that it was reviewing the input from commenters and will consider addressing the issues raised by the comments in future rules as appropriate.

Medicare Part B Drug Payment for Drugs Approved as Part of the Food, Drug, and Cosmetic Act

Medicare Part B covers drugs on a limited benefit for specific drugs and biologicals. These drugs and biologicals are in one of three categories and typically paid at an ASP+6 percent:

- Drugs and biologicals furnished incident to a physician's service(s)
- Drugs and biologicals administered via a covered item of durable medical equipment (DME)
- Other drugs and biologicals specified by statute.

Payments for separately payable Part B drugs and biologicals are defined using a methodology established within section 1847A of the Act, which involves assigning payable drug products to either a multiple or single source drug code for the purpose of payment. Drugs (which do not include biologicals or biosimilar biological products defined in section 1847A of the Act) fit into one of two mutually exclusive categories: multiple source drugs and single source drugs.

When assigning payment to newly marketed drugs, CMS looks at whether an existing multiple source drug code descriptor describes the new drug product and whether the active ingredient(s), drug name, and portions of the prescribing information coincide with existing products already assigned and paid under a multiple source drug code. The agency interprets this to mean that if there is an existing HCPCS code that includes two or more drug products that are rated to be therapeutically equivalent and meet the remaining conditions of multiple source drug code, the billing and payment is for a multiple source drug code.

If the product is assigned to an existing multiple source drug code, payment is based on the volume-weighted average ASP of all products assigned to the code, rather than based solely on its own ASP. As a result, a

multiple source drug code may include generic and branded drug products within an individual HCPCS code. A new single payment is determined based solely on its own ASP. When assigning a classification of services, CMS believes in maintaining consistency of payment by paying similar amounts for similar services.

CMS has identified a number of section 505(b)(2) drug products that are described by an existing multiple source drug code; however, these drugs are priced significantly higher than their related products. CMS is concerned about potential abuse of the system when drug products are assigned unique separate HCPCS codes despite being described by a multiple source drug code. CMS believes that assigning these drug products described to existing multiple source HCPCS codes is a method to curb drug prices. CMS proposed assigning certain drug products to existing multiple source drug codes if the products, as part of the Food, Drug, and Cosmetic Act, are described by an existing multiple source drug code and consistent with the interpretation of the definition of the multiple source drug code. In response to stakeholder feedback requesting more information on the details for how this would be applied, CMS delayed implementation of its proposals to allow the agency to further review and consider the issues presented.

As part of the proposed rule, CMS published a framework to build on the current CMS policy for assigning drug products to billing and payment codes. The agency is not proposing to adopt the framework at this time but rather seeks comments on the framework for future policy making. The framework includes a comparison of a drugs:

1. Active ingredient(s)
2. Dosage form (if part of the drug product name)
3. Salt form
4. Other ingredients in the drug product formulation.

If the drug product matches, the drug would continue onto a verification step that would compare the pharmacokinetic and clinical studies referenced on the FDA's approval labeling with the other drug products


assigned to an existing multiple source code. At this point, determination would be made regarding the assignment of the drug to the existing multiple source code.

CMS received several comments and feedback on its proposed framework. The agency indicated that it is taking the comments and suggestions under advisement for consideration in future rulemaking.

Services Provided by Physician Assistants

Currently, physician assistants (PAs) cannot bill independently for their services. In addition, all payments are made to the PA's employer, not directly to the PA. CMS proposed and finalized allowing PAs to bill for services directly to Medicare and the reimbursement for those services to be paid directly to the PA, which is similar to nurse practitioners (NPs) and clinical nurse specialists (CNSs) currently effective Jan. 1, 2022. PAs would be allowed to reassign their rights to payments for their services and may choose to incorporate as a group solely including practitioners in their specialty billing in the same manner as NPs and CNSs.

Removal of National Coverage Determination Positron Emission Tomography Scans

CMS proposed and finalized to remove national coverage determination (NCD) 220.6, positron emission tomography (PET) scans, to allow the Medicare administrative contractor (MAC) to make decisions of coverage per their beneficiaries. Stakeholder feedback suggests that the NCD is outdated, because it was originally created in 2000 to provide broad national non-coverage for non-oncologic indications of PET. This, in turn, created the need for every non-oncologic indication to have an individual NCD to receive coverage. CMS believes that by leaving this to the MACs to decide, the MACs can equip the necessary immediate means to provide coverage for non-oncologic indications or not provide coverage. 

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