The following summary of the rule and analysis was prepared for the Endocrine Society by Cavarocchi, Ruscio, and Dennis Associates.

CY 2021 PHYSICIAN FEE SCHEDULE FINAL RULE SUMMARY

On December 1, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) final rule for CY 2021. This rule updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP). The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found here.

The rule's provisions will be effective January 1, 2021 unless stated otherwise. The following summarizes the major policies in the proposal.

Conversion Factor and Specialty Impact (p. 1656)

The conversion factor for 2021 is $32.41, a decrease of $3.68 from the 2020 conversion factor of $36.09, but a slight increase from $32.26 as was proposed. This reduction of over 10 percent stems from the statutorily required budget neutrality adjustments required to accommodate the new spending on the outpatient evaluation and management (E/M) changes as well as other changes in the budget neutral system. Table 106 (see Appendix A), extracted from the rule, provides a summary of the impact of the changes in the proposed rule by specialty. The changes in the rule are budget-neutral in the aggregate, which explains why the impact for all physicians is shown as zero. The rule shows changes in the range of minus 10 percent to plus 16 percent with endocrinology receiving a 16 percent increase. However, the ultimate impact on an individual physician's reimbursement will depend on their case mix as the majority of services other than outpatient E/M have decreased. CMS responded to requests to use their authority under the public health emergency to mitigate the budget neutrality adjustment, which they declined to do. The agency says their waiver authority cannot be used for this purpose. The agency reiterated their approach to budget neutrality in this rule is consistent with how it has been achieved in previous rulemaking and in accordance with the statutory requirements.

As you will see from the attached chart, codes commonly billed by Endocrine Society members have significant decreases due to the budget neutrality adjustment.

Refinements to Values for Certain Services to Reflect Revisions to Payment for Office/Outpatient Evaluation and Management (E/M) Visits and Promote Payment Stability during the COVID-19 (p. 225)

BACKGROUND: In the CY 2020 PFS final rule, CMS adopted the CPT Editorial Panel's changes to the outpatient E/M family and set an effective date of January 1, 2021. Providers will no longer use history and physical exam to select the appropriate visit level, and E/M visits will include a medically appropriate history and exam when it is reasonable and necessary, and clinically appropriate. Visit level selection will be based on either the level of medical decision making (MDM) as redefined by CPT or the total face-to-face and non-face-to-face time spent by the reporting practitioner on the day of the visit.

CMS also finalized separate payment for a new prolonged visit add-on code, CPT code 99417, to report prolonged time associated with E/M visits, as well as separate payment for G2211 to provide payment for inherent visit complexity inherent to E/M 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 the ongoing care related to a patient's single, serious, or complex chronic condition. In this final rule, CMS creates a new G-code, G2212, to be used in place of CPT code 99417 for Medicare beneficiaries. More detail will be provided in the discussion below.

The agency included the time and work RVUs for the revised code family in Table 20, which can be found below.

TABLE 20: Summary of Codes and Work RVUs Finalized in the CY 2020 PFS Final Rule for CY 2021

HCPCS Code	Current Total Time (mins)	Current Work RVU	CY 2021 Total Time (mins)	CY 2021 Work RVU
99201	17	0.48	N/A	N/A
99202	22	0.93	22	0.93
99203	29	1.42	40	1.6
99204	45	2.43	60	2.6
99205	67	3.17	85	3.5
99211	7	0.18	7	0.18
99212	16	0.48	18	0.7
99213	23	0.97	30	1.3
99214	40	1.5	49	1.92
99215	55	2.11	70	2.8
G2212	N/A	N/A	15	0.61
G2211	N/A	N/A	11	0.33

A detailed description of the E/M policies in this rule for implementation in 2021 follows:

TIME VALUES FOR OUTPATIENT E/M VISIT CODES: The RUC survey of the revised code set asked respondents to consider the total time spent on the day of the visit, as well as any pre- and post-service time occurring within 3 days prior to and 7 days after the visit. The RUC separately averaged the survey results for pre-service, day of service, and post-service times, and the survey results for total time, as a result the sum of the times associated with the three services periods did not match the RUC-recommended total time for some codes in the family. CMS finalized the RUC-recommended times in last year's rule despite these discrepancies in time, but this year the agency finalized its proposal to adopt total times for this code family that equal the sum of the component parts to be consistent with how total times are calculated for other MPFS services.

COMMENT SOLICITATION ON DEFINITION OF G2211: CMS finalized the HCPCS add-on code G2211 in the 2020 MPFS because they believe that the outpatient E/M codes still do not fully reflect the resources associated with primary care and certain types of specialty visits. They believe the inclusion of add-on code G2211 appropriately recognizes the resources involved when practitioners furnish services that are best-suited to patients' ongoing care needs and potentially evolving illness and this work is

inherently distinct from existing coding that describes preventive and care management services. G2211 reflects the time, intensity, and practice expense when practitioners furnish services that enable them to build longitudinal relationships with all patients and to address the majority of patients' health care needs with consistency and continuity over longer periods of time. CMS also believes this add-on code could bolster the efforts of practitioners in rural communities, including NPPs, to deliver the comprehensive and longitudinal care.

CMS feels this description of G2211's use is clear, but also outlined situations when its use would be inappropriate: the care furnished during the 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. The agency also did not think it would be appropriate to bill G2211 when modifier -25 is used as visits reported with payment modifiers have resources that are sufficiently distinct from stand-alone office/outpatient E/M visits. CMS stated they will consider this issue to inform future rulemaking.

The agency confirms the code can be billed with both new and established patient visits. Billing for this service will not be restricted by specialty as had been proposed for the initial add-on codes in the CY 2019 PFS proposed rule.

CMS did make minor modifications to the code to descriptor in the final rule which now reads as follows: 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).

Stakeholders had expressed concerns regarding documentation for this code. CMS referred to the CY 2019 MPFS final rule to explain their documentation expectations and expressed their intention not to create additional documentation burden. They would expect that information included in the medical record or in the claims history for a patient/practitioner combination, such as diagnoses, the practitioner's assessment and plan for the visit, and/or other service codes billed could serve as supporting documentation.

Since G2211 is a new code, CMS plans to monitor utilization for appropriate use of the add-on code, which could inform future refinements to the code descriptor, or provide further guidance, as appropriate. Medicare claims may also be a gauge of appropriate use of the code. The agency did revise

its utilization assumptions for the code: they now believe it will be billed with 90, rather than 100, percent of outpatient E/M services that meet the code's requirements.

PROLONGED OUTPATIENT E/M VISITS (CPT CODE 99417/G2212): CMS had previously finalized CPT code 99417 to be reported when the time of the physician or qualified healthcare professional is used to select the visit level. CMS interpreted the revised CPT prefatory language and reporting instructions would mean that CPT code 99417 could be reported when the physician's (or NPP's) time is used for code level selection and the time for a level 5 office/outpatient E/M visit (the floor of the level 5 time range) is exceeded by 15 minutes or more on the date of service in the 2020 PFS. However, CMS believes the intent of the CPT Editorial Panel with respect to 99417 is unclear because of the use of the terms "total time" and "usual service" in the CPT code descriptor ("requiring total time with or without direct patient contact beyond the usual service."). Now CMS believes allowing reporting of CPT code 99417 after the minimum time for the level 5 visit is exceeded by at least 15 minutes would result in double counting time. To avoid this, the agency proposed that CPT code 99417 could only be reported when the maximum time for the level 5 visit is exceeded by at least 15 minutes on the date of service.

In the final rule, CMS reiterated that they believe CPT code 99417 as written is unclear and allowing reporting of this code when the minimum required time for the level 5 visit is exceeded by at least 15 minutes would result in double counting time. While many stakeholders commented that CMS should allow for reporting of this code when the midpoint of the additional 15 minutes was exceeded, the agency does not believe this was CPT's intent and never intended to apply such a policy.

CMS finalized the proposal allowing time to be counted for prolonged office/outpatient E/M visits once the upper limit of the level 5 service has been met. To resolve the potential inconsistency of this policy with CPT code 99417, the agency finalized a new HCPCS code G2212 to be used when billing Medicare for this service instead of CPT code 99417. The value of HCPCS code G2212 will be the same as for CPT code 99417.

The descriptor for G2212 is as follows: 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)).

REVALUING SERVICES ANALOGOUS TO OUTPATIENT E/M VISITS: CMS identified services, other than the global surgical codes, with values closely tied to the outpatient E/M codes, including transitional care management (TCM) services; cognitive impairment assessment and care planning; certain end-stage renal disease (ESRD) services; emergency department visits, therapy evaluations, certain behavioral health services; and the annual wellness visit (AWV) and initial preventive physical exam (IPPE). Many of these services were valued via building block methodology and have outpatient E/M

services built into their definition or value. Unlike the 10- and 90-day global surgical services codes, CMS never expressed concerns regarding the accuracy of the values of the maternity packages, and these services were not part of the policy adopted to transition all 10- and 90- day globals to 0-day globals (79 FR 67591), though that policy was overridden by statutory amendments before it took effect.

Telehealth and Other Services Involving Communications Technology (p. 74)

CMS proposed to add a number of services to the Medicare telehealth list permanently and others temporarily. The agency also discusses a number of services on the list temporarily during the PHE that were not proposed to be on the list permanently. A more detailed summary of the discussion of these categories follow. Table 12 from the rule summaries the agency's proposals by code.

Permanent Addition of Services to the Telehealth List

Services may be added to the list of permanent Medicare telehealth services if they meet CMS' Category 1 or 2 criteria which are:

- Category 1: Services that are similar to professional consultations, office visits, and office psychiatry services that are currently on Medicare telehealth services list. In reviewing these requests, CMS looks for similarities between the requested and existing telehealth services for the roles of, and interactions among, the beneficiary, the physician (or other practitioner) at the distant site and, if necessary, the telepresenter, a practitioner who is present with the beneficiary in the originating site. The agency also looks for similarities in the telecommunications system used to deliver the service; for example, the use of interactive audio and video equipment.
- Category 2: Services that are not similar to those on the current Medicare telehealth services list. The review of these requests includes an assessment of whether the service is accurately described by the corresponding code when furnished via telehealth and whether the use of a telecommunications system to furnish the service produces demonstrated clinical benefit to the patient. Submitted evidence should include both a description of relevant clinical studies that demonstrate the service furnished by telehealth to a Medicare beneficiary improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part, including dates and findings, and a list and copies of published peer reviewed articles relevant to the service when furnished via telehealth. The evidentiary standard of clinical benefit does not include minor or incidental benefits.

CMS is finalizing its proposal to add nine services to the permanent Medicare telehealth services list for CY 2021. The complete list of codes and their descriptions are included in Table 11 on page 101 in the final rule. The agency believes these services are similar to those already included on the list.

Some domiciliary and rest home visits are on this list. While a patient's home is statutorily prohibited from serving as an originating site for most telehealth services, the domiciliary/home visits contain the same elements and have similar descriptors to the outpatient E/M visits for which the home can serve as an originating site under authority granted under the SUPPORT Act for the purposes of treatment of a substance abuse disorder or a co-occurring mental health disorder. Therefore, as finalized, CPT codes

99334-99335 and 99347-99348 would only be furnished via telehealth for the treatment of these conditions.

The complete Medicare telehealth services list is available on the CMS website here.

Proposed Temporary Addition of Services to the Medicare Telehealth List

CMS finalized its proposal to create a new category of services (Category 3) to the telehealth list during the PHE which will remain there on a temporary basis through the end of the year the PHE ends. This would include services that were added during the PHE for which there is likely to be a clinical benefit when furnished via telehealth, but for which there is not yet sufficient evidence available to adding the service permanently under existing criteria. The categories of services on the final list of services for temporary addition to the Medicare telehealth service list (category 3 services) include:

- End-stage renal disease monthly capitation payment services;
- Emergency department visits;
- Domiciliary, rest home, or custodial care services for established patients;
- Home visits for established patients;
- Nursing facilities discharge day management;
- Psychological and neuropsychological testing;
- Therapy services, physical and occupational therapy, all levels;
- Subsequent observation and observation discharge day management;
- Initial hospital care and hospital discharge day management;
- Critical care services;
- Inpatient neonatal and pediatric critical care, subsequent; and
- Continuing neonatal intensive care services.

A complete list of services and their descriptors can be found in Table 13 on page 115 in the final rule. Since the PHE has been extended into 2021, providers until the end of 2021 to collect evidence to support a request to add these services permanently to the Medicare telehealth list.

Comment Solicitation on Medicare Telehealth Services Added on an Interim Basis during the PHE that CMS is not Proposing to Retain after the PHE Ends

Outside of the PHE, CMS does not believe that certain services added to the telehealth list during the PHE could be provided fully and effectively via telehealth. However, CMS requested comment on whether some of these services should be added to the list on a temporary basis or permanently. The categories of services on which the agency specifically requested comments on their concerns include initial and final/discharge interactions; higher level emergency department visits; and hospital, intensive care unit, emergency care, observation stays. In response to stakeholder feedback and evidence gathered, CMS finalized additional services to remain temporarily on the Medicare telehealth list through the end of the year on which the PHE ends (Category 3 services). Many comments requested that CMS add specific interim PHE telehealth services that the agency did not propose to add to the Medicare telehealth list on a Category 3 basis. Table 15 on page 128 in the final rule includes a complete

list of Category 3 requests. Table 16 (found below) includes a summary of all the services added to the Medicare telehealth services list.

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.

Proposed Technical Amendment to Remove References to Specific Technology

The final sentence of CMS' regulation at § 410.78(a)(3) prohibits the use of telephones, fax machines, and email systems for purposes of furnishing Medicare telehealth services. The first COVID interim final rule suspended the application of this sentence during the PHE, but in this rule, CMS is finalizing its proposal to eliminate this sentence.

Communication Technology-Based Services (CTBS)

CMS has previously finalized separate payment for a number of services that could be furnished via telecommunications technology, but are not considered telehealth services, including HCPCS codes

G2010 and G2012, remote evaluation of recorded video and or images and the virtual check-in respectively. In the first COVID interim final rule, CMS finalized policy to allow physical therapists, occupational therapists, and speech language pathologists who bill Medicare directly to bill G2061 through G2063, the qualified nonphysician healthcare professional online assessment and management services, during the PHE, and finalized this policy on a permanent basis. The agency also finalized its proposal to allow certain nonphysician practitioners to bill CTBS consistent with the scope of their benefit categories through two new G codes:

- G2250 *(Remote assessment of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related service provided within the previous 7 days nor leading to a service or procedure within the next 24 hours or soonest available appointment.)*
- G2251 *(Brief communication technology-based service, e.g. virtual check-in, by a qualified health care professional who cannot 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 a service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion)*

CMS finalized its proposal to value these services identically to HCPCS codes G2010 and G2012, respectively.

For these CTBS, CMS clarified that the consent from the patient to receive these services can be documented by auxiliary staff under general supervision, as well as by the billing practitioner. Additionally, in instances when the brief CTBS originates from a related E/M service (including one furnished as a telehealth service) provided within the previous 7 days by the same physician or other qualified health care professional, this service would be considered bundled into that previous E/M service and would not be separately billable.

Comment Solicitation on Continuation of Payment for Audio-only Visits
CMS added the audio-only telephone E/M services to the telehealth services list during the PHE and did not propose to continue payment for these services once the PHE concludes because the agency does not regularly have the authority to waive the requirement that telehealth services be delivered using an interactive telecommunications system that includes two-way audio and visual communications technology. The agency considered these services as telehealth services during the PHE because they were being delivered in place of outpatient E/M visits.

In the final rule, the agency continues to believe that their regulatory interpretation of "telecommunications system" precludes the use of audio-only technology for purposes of Medicare telehealth services, outside of the PHE. After the conclusion of the PHE, CMS will not provide separate payment for the audio-only E/M visit codes, and the agency will assign a status of "bundled" and post the RUC-recommended RVUs for these codes in accordance with their usual practice.

The agency recognizes there may be circumstances where a longer telephone conversation may be necessary to determine whether an in-person visit is necessary. CMS sought comment on whether a code should be developed and valued to describe a longer virtual check-in as well as the appropriate duration interval for such services and the work and PE resources required.

CMS recognizes that outside of the circumstances of the PHE for COVID-19, Medicare does not provide separate payment for a service that would be a substitute for an in-person visit but is furnished using audio-only technology. In the final rule, CMS is establishing on an interim basis for CY 2021 payment for a new HCPCS G-code for a virtual check-in describing 11-20 minutes of medical discussion to determine the necessity of an in-person visit.

- 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.)*

CMS finalized a work RVU of 0.50, direct PE inputs of 3 minutes of clinical labor code L037D, and 1 minute, 15 minutes, and 5 minutes of pre, intra and post service time, respectively. CMS clarified that this service is not a substitute for an in-person visit, but rather an assessment to determine the need for one. If this service originates from a related E/M service provided within the previous 7 days or leads to an E/M service or procedure within the next 24 hours (or soonest available appointment) it would be considered bundled into that in-person service.

Comment Solicitation on Coding and Payment for Virtual Services

There are a number of services, like chronic care management and remote physiologic monitoring, that are inherently non face-to-face services and are not telehealth services, falling outside the restrictions on telehealth services. CMS sought comment on whether there are additional services that fall outside of telehealth services under section 1834(m) where it would be helpful to clarify these services do not need to be on the telehealth list in order to be billed and paid when furnished using telecommunications technology rather than in person with the patient present. The agency also requested comment on physicians' services that involve technology that may not be fully recognized by current fee schedule coding and payment as well as any comments on any impediments that contribute to health care provider burden and would make providers reluctant to bill for CTBS. CMS thanks commenters for their suggestions and will consider them for future rulemaking.

Proposed Clarification of Existing PFS Policies for Telehealth Services

CMS believes that services provided incident to the professional services of an eligible distant site physician or practitioner could be reported when they meet direct supervision requirements at both the originating and distant site through the virtual presence of the billing physician or practitioner. The agency is finalizing its proposed clarification that telehealth services may be furnished and billed when provided incident to a physicians' service and under the direct supervision of the billing professional

through virtual communication. Additionally, time should be counted for telehealth services furnished by auxiliary personnel incident to a billing professional's services in the same way time is counted for other "incident to" services.

Direct Supervision by Interactive Telecommunications Technology
CMS finalized its proposal to allow direct supervision to be provided using real-time, interactive audio and video technology through the later end of the calendar year in which the PHE ends. This requires the supervising physician to be immediately available to engage via audio/video technology (excluding audio-only) and would not require real-time presence or observation of the service via interactive audio and video technology through the performance of the procedure.

CMS sought comment on whether there should be any additional "guardrails" or limitations to ensure patient safety/clinical appropriateness beyond typical clinical standards, as well as restrictions to prevent fraud or inappropriate use if this policy is finalized on a temporary basis. The agency will consider the comments it received as they determine future policy regarding use of communication technology to satisfy direct supervision requirements as well as the best approach for safeguarding patient safety while promoting use of technology to enhance access.

Practice Expense - Update on Technical Expert Panel Related to Practice Expense (p. 80)
CMS contracted with the RAND Corporation to study potential improvements to CMS' PE allocation methodology and the data that underlie it. Currently, the PE RVUs are based in part in the Physician Practice Information Survey administered by the American Medical Association in 2007 and 2008. RAND has concluded that the PPIS data are outdated. Their study found that practice ownership was strongly associated with indirect PE, with physician-owned practices requiring 190 percent higher indirect PE compared to facility-owned practices. It also found that aggregating Medicare provider specialties into broader categories resulted in small specialty-level impacts relative to the current system, suggesting that specialty-specific inputs may not be required to accurately reflect resource codes.

Earlier this year, RAND convened a technical expert panel (TEP) to obtain stakeholder input on issues ranging from identifying issues with the current system; changes in medicine that have affected PE; how PE inputs could be updated; how to best aggregate PE categories in a new survey instrument; ways to maximize response rates in a potential survey; and using existing data to inform MPFS PE rates.

Based on the results of the TEP and RAND's ongoing research, CMS is interested in potentially refining the PE methodology and updating the data used to make MPFS payments. The agency is considering how to best incorporate market-based information and how to update the clinical labor data. Specifically, CMS is interested in whether the data from the Bureau of Labor Statistics is the best source for this data. The agency finalized the plan to hold a future Town Hall meeting to discuss this topic.

Valuation of Specific Codes
Fine Needle Aspiration (CPT codes 10021, 10004, 10005, 10006, 10007, 10008, 10009, 10010, 10011, and 10012) (p. 390)

This code family was revised by CPT in 2017 and then valued by the RUC at the January 2018 meeting. Following the publication of the CY 2019 final rule, RUC staff stated that CMS erroneously double-counted the utilization for new codes that had image guidance bundled. CMS disagreed that this constituted a technical error and communicated to the RUC in conversations following the publication of the rule that the surveying specialties could instead nominate the affected codes from these families as being potentially misvalued and provide new information that was not already presented to the agency for review. At the January 2020 RUC meeting, the RUC reaffirmed its CY 2019 recommendations for physician work and direct practice expense (PE) for the ten codes in the Fine Needle Aspiration code family. CMS did not make any changes to the value of these services finalized the CY 2019 final rule and would look forward to receiving any new information or data rather than reaffirmation of the previous RUC review.

Insertion, Removal, and Removal and Insertion of Implantable Interstitial Glucose Sensor System (Category III CPT codes 0446T, 0447T, and 0448T) (p. 546)

Category III CPT codes 0446T, 0447T, and 0448T describe the services related to the insertion, removal, and removal and insertion of an implantable interstitial glucose sensor from a subcutaneous pocket, in a subcutaneous pocket via incision. The implantable interstitial glucose sensors are part of systems that can allow real-time glucose monitoring, provides glucose trend information, and signal alerts for detection and prediction of episodes of low blood glucose (hypoglycemia) and high blood glucose (hyperglycemia). The codes that describe the implantation, removal, and removal and implantation of implantable interstitial glucose sensors are currently contractor-priced.

CMS had requested information from stakeholders on the proper valuation for these services in the CY 2020 Physician Fee Schedule final rule. The agency finalized its proposal for national payment amounts for this code family by crosswalking these services to the work and direct PE values of the drug delivery impact code family, resulting in work RVUs of 1.14, 1.34. and 1.91 for CPT codes 0446T, 0447T, and 0448T respectively.

The agency also proposed one new supply and one equipment item to the direct PE inputs. This will include adding a new "implantable interstitial glucose sensor" (supply code SD334) for Category III CPT codes 0446T and 0448T to include the supply costs of the "implantable interstitial glucose sensor" (supply code SD334) included in these procedures with a proposed price of $1500. The agency is also proposing to include the smart transmitter associated with the use of this implantable interstitial glucose sensor with a price of $1000. CMS finalized this proposal with one modification: the removal of equipment package EQ392 from Category III CPT code 0448T based on comments that stated there was no need to report the cost of the transmitter with this service.

Chronic Care Management Services (CPT code 99439 and HCPCS code G2058) (p. 524)

CMS established payment for HCPCS code G2058 (Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified healthcare professional, per calendar month) in the CY 2020 PFS final rule (84 FR 62690). At the January 2020 RUC meeting, specialty societies requested a temporary crosswalk through CY 2021 between the value established by CMS for

HCPCS code G2058 and the value of new CPT code 99439 (with a descriptor identical to G2058). The Chronic Care Management code family will be resurveyed during CY 2020 and is expected to be presented for review as part of the 2022 RUC review process. For CY 2021, CMS finalized the RUC-recommended work RVU of 0.54 and the RUC recommended direct PE inputs for CPT code 99439.

Care Management Services and Remote Physiologic Monitoring Services (p. 202)

CMS proposes a number of code refinements related to remote physiologic monitoring (RPM), transitional care management (TCM), and psychiatric collaborative care model (CoCM) services to improve payment for care management services.

Digitally Stored Data Services/Remote Physiologic Monitoring/Treatment Management Services (RPM)

For CY 2021, CMS clarifies how they read CPT code descriptors and instructions associated with CPT codes 99453, 99454, 99091, and 99457 (and the add-on code, CPT code 99458) and their use to describe remote monitoring of physiologic parameters of a patient's health. CPT codes 99453 *(Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment)* and 99454 is valued to reflect clinical staff time that includes instructing a patient and/or caregiver about using one or more medical devices. CPT code 99454 *(Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry,respiratory flow rate), initial; device(s) supply with daily recording(s) or programmed alert(s)transmission, each 30 days)* are PE only codes that include clinical staff time, supplies, and equipment, including the medical device for the typical care of remote monitoring. For the latter code, the agency clarified that the medical device or devices that are supplied to the patient to collect the data are considered equipment and are direct PE inputs for the code.

The devices included in these codes must be a device as defined by the Food and Drug Administration (FDA) but are not required to be cleared by the agency. There is also no requirement that the device be prescribed by a physician. CMS clarified that the medical device in CPT code 99454 should digitally (automatically) upload patient physiologic data; be reasonable and necessary for the diagnosis or treatment of the patient; and be used to collect and transmit reliable and valid physiologic data that allow understanding of a patient's health status to develop and manage a plan of treatment.

The whole family can only be billed by physicians or nonphysician practitioners who are eligible to bill Medicare for E/M services. CMS further clarified that these services may be furnished to remotely collect and analyze physiologic data from patients with acute as well as chronic conditions.

CPT code 99091 *(Collection and interpretation of physiologic data (e.g., 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)* includes only professional work and has no direct PE input, therefore, this service can only be those providers who can bill Medicare directly, not clinical staff. CPT codes 99457 *(Remote physiologic monitoring treatment management*

services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes) and 99458 *(Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; each additional 20 minutes (list separately in addition to code for primary procedure))* describe the treatment and management services associated with RPM and can be furnished by clinical staff under the general supervision of the physician or NPP. Furthermore, these two services are typically furnished remotely with communications technology that allow "interactive communication," which the agency defined as "at a minimum, a real-time synchronous, two-way audio interaction that is capable of being enhanced with video or other kinds of data transmission."

CMS finalized two of its interim RPM policies – to allow consent to be obtained at the time the RPM service is furnished and to allow auxiliary personnel to furnish the services described by CPT codes 99453 and 99454 under the general supervision of the billing practitioner. However, only established patients will be eligible to receive these services once the PHE ends, as reaffirmed by CMS in the final rule.

In the response to the executive order titled "Regulatory Relief to Support Economic Recovery," CMS requested comment on whether the current RPM coding accurately and adequately describes the full range of clinical scenarios where RPM services may be of benefit to patients, specifically whether they should consider establishing coding and payment rules that would allow practitioners to bill for RPM services with shorter monitoring periods. The agency appreciated commenters' thoughts on whether one or more codes that describe a shorter duration, for example, eight or more days of remote monitoring within 30 days, might be useful, as well as the clarifications provided in the rule regarding the use of these services.

Transitional Care Management (TCM)

CMS finalized its proposal to remove 14 additional actively priced HCPCS codes from the list of remaining HCPCS codes that cannot be billed concurrently with TCM as well as to allow the new Chronic Care Management HCPCS code G2058 to be billed concurrently with TCM when reasonable and necessary. The minutes counted for the TCM services cannot also be counted towards other services. See Table 18 for the full list of services CMS that can be billed concurrently with TCM services.

TABLE 18: 15 Additional Codes That Could Be Billed Concurrently with TCM

Code Family	CPT Code	Descriptor
End Stage Renal Disease Services (for ages less than 2 months through 20+ years)	90951	ESRD related services with 4 or more face-to-face visits per month; for patients <2 years of age
	90954	ESRD related services with 4 or more face-to-face visits per month; for patients 2-11 years
	90955	ESRD related services with 2-3 face-to-face visits per month; for patients 2-11 years
	90956	ESRD related services with 1 face-to-face visit per month; for patients 2-11 years
	90957	ESRD related services with 4 or more face-to-face visits per month; for patients 12-19 years
	90958	ESRD related services with 2-3 face-to-face visits per month; for patients 12-19 years
	90959	ESRD related services with 1 face-to-face visit per month; for patients 12-19 years
	90963	ESRD related services for home dialysis per full month; for patients <2 years of age
	90964	ESRD related services for home dialysis per full month; for patients 2-11 years
	90965	ESRD related services for home dialysis per full month; for patients 12-19 years
	90966	ESRD related services for home dialysis per full month; for patients 20 years and older
	90967	ESRD related services for dialysis less than a full month of service; per day; for patients <2 years of age
	90968	ESRD related services for dialysis less than a full month of service; per day; for patients 2-11 years
	90969	ESRD related services for dialysis less than a full month of service; per day; for patients 12-19 years
Complex Chronic Care Management Services	HCPCS G2058 (Beginning CY 2021, CPT code 99439)	Chronic care management services, each additional 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month

Scope of Practice and Related Issues (p. 266)

CMS recognizes that certain supervision requirements were more restrictive than existing state scope of practice laws, and limit health professionals from practicing at the top of their license. CMS believes the finalized policies outlined in this section will ensure that health professionals are able to provide services to beneficiaries in accordance with their scope of practice and state licensure, and may help to address physician shortage issues in the country, as well as help to alleviate the opioid crisis. None of these changes preempt state laws.

Teaching Physician and Resident Moonlighting Policies

In the proposed rule, CMS considered whether the following policies, implemented in the March 31 and May 1 interim final rules with comment period (IFCs), should be extended on a temporary basis, until December 31, 2021, or be made permanent once the PHE concludes.

- Supervision of Residents in Teaching Settings through Audio/Video Real-Time Communications Technology

CMS is finalizing a permanent policy to allow teaching physicians to meet the requirements to bill for their services involving residents through virtual presence, but only for services furnished in residency training sites that are located outside of an OMB-defined metropolitan statistical area (MSA). CMS believes that permitting the teaching physician to meet the requirements to bill under the PFS for their services through virtual presence when furnishing services involving residents in rural training settings could increase access to Medicare-covered services by preventing the beneficiary from potentially having to travel long distances to obtain care, particularly as rural areas have stretched and diminishing

clinical workforces. Additionally, CMS hopes this policy will improve teaching capabilities and allow for additional resident education opportunities in rural areas.

CMS is not finalizing this policy for other settings on a permanent; however, for the duration of the PHE, CMS will continue to allow teaching physicians to meet the requirements to bill for their services involving residents through audio/video real-time communication technology, during a portion of the patient visit or interpretation of diagnostic radiology or test.

- Virtual Teaching Physician Presence during Medicare Telehealth Services

CMS finalized policy on a permanent basis that allows Medicare to make payment under the PFS for teaching physician services when a resident furnished Medicare telehealth services in a residency training site located outside of a MSA to a beneficiary who is in a separate location outside the same MSA (i.e. in the same rural area) as the residency training site or is within a rural area outside of a different MSA, while a teaching physician is present, through interactive, audio/video real-time communications technology.. The patient's medical record must clearly reflect how and when the teaching physician was present during the key portion of the service, in accordance with our regulations.

CMS is not finalizing this policy in other settings; however, the flexibility will remain in place for the duration of the PHE.

- Resident Moonlighting in the Inpatient Setting

CMS finalized its interim policy for the services of moonlighting residents, on a permanent basis. CMS is amending its regulations to state that services of residents that are not related to their approved Graduate Medical Education (GME) programs and are furnished to inpatients of a hospital in which they have their training program are separately billable physicians' services for which payment can be made under the PFS. CMS specified that these services must be separately identified from the services that are required as part of the approved GME program.

CMS is requiring that the patient's medical record reflect the following:

1. The resident furnished identifiable physician services that meet the conditions of payment of physician services to beneficiaries;
2. The resident is fully licensed to practice medicine, osteopathy, dentistry, or podiatry by the State in which the services are performed; and
3. The services were performed outside of their approved GME program.

- Primary Care Exception Policies

During the PHE, CMS adopted interim policy to allow Medicare to make payment to the teaching physician for additional services under the primary care exception, including all levels of office and

outpatient E/M, audio-only telephone E/M services, transitional care management, and communication technology-based services.

In the final rule, CMS finalized a permanent policy for residency training sites that are located outside of a MSA to allow Medicare to make payment to the teaching physician when the resident furnishes an expanded array of services under the primary care exception. In addition to the lower and mid-level complexity services within the scope of the primary care exception, CMS is limiting the permanent expanded array of services under the primary care exception to include CTBS and interprofessional consults. These services are described by CPT codes 99421-99423, and 99452, and HCPCS codes G2010 and G2012. CMS is not adding the office/outpatient E/M level 4 visits to the primary care exception. CMS is also adding Medicare telehealth services that are furnished by residents to the primary care exception for residency training sites that are located outside of an MSA.

For all other settings, CMS is not implementing a permanent policy to allow Medicare to make payment to the teaching physician when the resident furnishes an expanded array of services under the primary care exception, including when those services are furnished under Medicare telehealth. However, the current interim policy including an expanded set of services under the primary care exception will remain in place for the duration of the PHE. At the end of the PHE, CMS will be terminating the inclusion of CPT codes 99204, 99214, 99205, 99215, 99495 and 99496 from the primary care exception for all settings.

- Payment Under the PFS for Teaching Physician Services When Resident Under Quarantine

CMS finalized that, for the duration of the PHE, PFS payment can be made for teaching physician services that do not require face-to-face patient care when the resident is furnishing such services while in quarantine when the teaching physician is present through audio/video real-time communications technology.

Supervision of Diagnostic Tests by Certain NPPs

Prior to the COVID-19 pandemic, only physicians were permitted to supervise diagnostic tests. In the May 1 IFC, CMS finalized on an interim basis, a policy which allows PAs and NPs, and certain other NPPs to supervise diagnostic tests. In this final rule, CMS is amending current regulations to allow nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs), certified nurse-midwives (CNMs), and certified registered nurse anesthetists (CRNAs) to supervise diagnostic tests on a permanent basis, as allowed by state law and scope of practice. CMS also finalized its proposal to amend regulations to specify that diagnostic tests performed by a PA in accordance with their scope of practice and State law do not require a specified level of physician supervision assigned to individual diagnostic tests.

Pharmacists Providing Services Incident to Physicians' Services

In this proposed rule, CMS is clarifying that pharmacists may provide services "incident to" the services of the billing physician or NPP, if payment for the services is not made under the Medicare Part D

benefit. CMS believes this clarification may relieve burden on physicians and NPPs and increase access to medication management services for beneficiaries with chronic conditions. CMS also noted that this clarifies the ability of pharmacies to enroll as laboratories and work with physicians in the assessment of clinical information, specimen collection and reporting results of COVID-19 clinical diagnostic laboratory tests (CDLTs).

Medical Record Documentation

CMS is clarifying that physicians and NPPs, including therapists can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the MPFS. Residents and students working under a physician or practitioner who furnishes and bills directly for their services to the Medicare program, may also document in the record as long as it is reviewed and verified by the billing physician, practitioner, or therapist.

Proposal to Remove Selected National Coverage Determinations (p. 916)

CMS appreciated stakeholder feedback on guidelines for how the agency should remove outdated NCDs that are no longer clinically relevant, and is moving forward with the process for this final rule and future rulemaking. CMS clarifies that once an NCD is removed for an item or service, the item or service is no longer nationally covered by Medicare, and instead, the coverage determinations for those items and services will be made by the local Medicare Administrative Contractors (MACs).

CMS finalized the removal of the following NCDs:

- 20.5 - Extracorporeal Immunoadsorption (ECI) using Protein A Columns (01/01/2001)
- 30.4 - Electrosleep Therapy
- 100.9 - Implantation of Gastroesophageal Reflux Device (06/22/1987)
- 110.19 - Abarelix for the Treatment of Prostate Cancer (3/15/2005)
- 220.2.1 - Magnetic Resonance Spectroscopy (09/10/2004)
- 220.6.16 - FDG PET for Inflammation and Infection (03/19/2008)

CMS retained the following NCDs and will continue to engage with stakeholders on whether it is appropriate for removal in next year's rulemaking based on the comments received:

- 110.14 - Apheresis (Therapeutic Pheresis) (7/30/1992)
- 190.1 - Histocompatability Testing
- 190.3 - Cytogenetic Studies (7/16/1998)

Medicare Diabetes Prevention Program (MDPP) Expansion Provisions (p. 1020)

Changes to Sec 410.79(b)—Program Flexibilities

CMS finalized revisions to several of the policies from the March 31 interim final rule (IFC) that would apply during the remainder of the COVID-19 public health emergency (PHE) and/or any future emergency period where the Secretary authorizes section 1135 waivers. These "applicable 1135 waiver events" would be determined to disrupt in-person MDPP services if MDPP suppliers would likely be

unable to conduct classes in person, or if beneficiaries would be unable to attend in-person classes for health and safety reasons. The agency would notify impacted MDPP suppliers of an 1135 waiver event that may disrupt in-person services in the future. CMS believes that establishing an Emergency Policy that applies more broadly than the COVID-19 PHE will provide for flexibility to address future applicable 1135 waiver events. These changes supersede the flexibilities finalized in the March 31 IFC.

The revised flexibilities would be applicable to all MDPP beneficiaries and suppliers. While the Emergency Policy permits MDPP services to be furnished entirely on a virtual basis, it does not permit virtual-only suppliers to participate in the MDPP unless the supplier's preliminary or full CDC Diabetes Prevention Recognition Program (DPRP) recognition authorizes the supplier to furnish services in-person. Since MDPP services are covered under Medicare only when they are furnished at least in part in-person, virtual-only suppliers may not provide MDPP services, either virtually or in-person. Suppliers must be prepared to resume delivery of MDPP services in-person after the 1135 waiver event ends, and virtual-only suppliers may not have time to obtain CDC recognition to furnish in-person services.

During an applicable 1135 waiver event, CMS will allow MDPP suppliers to start new cohorts, and to either deliver MDPP services virtually or suspend in-person services and resume them at a later date. These changes would allow certain beneficiaries to receive the set of MDPP services more than once per lifetime, since the beneficiary would maintain eligibility for MDPP services despite a break in attendance. However, MDPP beneficiaries who elect to continue to receive services virtually will not be able to restart the set of MDPP services at a later date. CMS will allow MDPP beneficiaries receiving the MDPP set of services virtually to suspend MDPP services and later resume the set of in-person MDPP services with the most recent attendance session of record once in-person services are available.

For beneficiaries who do not elect to receive services virtually, the following approach will be taken. MDPP beneficiaries in the first 12 months of the set of MDPP services at the start of the applicable 1135 waiver event would be eligible to restart the set of MDPP services either at the beginning, or resume with the most recent attendance session recorded, after the applicable 1135 waiver event ends. MDPP beneficiaries in the maintenance period, or second year, would only be allowed to resume the set of services with the most recent attendance session recorded. MDPP beneficiaries that elect to suspend the set of services at the start of the applicable 1135 waiver event and subsequently to restart the services may only make one such election per 1135 waiver event. These flexibilities will apply to all MDPP beneficiaries who were receiving MDPP services as of March 31, 2020, in order to include those beneficiaries who started MDPP services in the month of March, given that state shelter-in-place orders varied significantly.

CMS is removing the limit placed on the number of virtual make-up sessions from the March 31 IFC, and will allow all sessions, including the first core session, to be offered as a virtual class consistent with the in-person class curriculum. MDPP supplies will be allowed to offer the following virtual sessions:

- 16 virtual sessions offered weekly during the core session period;
- 6 virtual sessions offered monthly during the core maintenance session interval periods; and
- 12 virtual sessions offered monthly during the ongoing maintenance session interval periods.

MDPP suppliers will only be able to furnish a maximum of one regularly scheduled session per week and one virtual make-up session per week to a beneficiary. CMS increased the number of allowable virtual core sessions from 15 to 16, and noted that the requirement for in-person attendance at the first core session would not apply during the 1135 waiver event.

Virtual sessions will be allowed to be furnished to achieve both attendance goals and weight-loss goals if a qualifying weight measurement is obtained. MDPP suppliers may obtain weight measurements through the following proposed methods:

- In-person, when the weight measurement can be obtained safely and in compliance with applicable laws and regulations;
- Via digital technology, such as Bluetooth-enabled scales; or
- Self-reported weight measurements from a participant's home digital scale by submitting a time and date-stamped photo or video of their home scale with their current weight measurement, or by using synchronous, online video technology such as video chatting or video conferencing with an MDPP coach, where the coach can clearly observe the self-recorded weight of the beneficiary.

CMS clarified that they did not intend to eliminate the waiver of the minimum weight loss requirement for beneficiary eligibility in the ongoing maintenance session intervals for MDPP beneficiaries who were receiving the MDPP set of services prior to January 1, 2021.

Changes to §424.210---Flexibilities for Incentives

MDPP suppliers may furnish in-kind beneficiary engagement incentives to a beneficiary if they are furnished during the "engagement incentive period." The disruption to MDPP services caused by an applicable 1135 waiver event may cause the supplier not to have contact with beneficiaries for more than 90 consecutive calendar days as required under the regulations. CMS did not finalize the proposal to amend the definition of "engagement incentive period" to qualify when the period ends in the case of an applicable 1135 waiver event. The engagement incentive period will end if the MDPP supplier has not had direct contact with the MDPP beneficiary, whether in person, by telephone, or via other telecommunications technology, for more than 90 consecutive calendar days during the MDPP services period. Under this provision, the engagement incentive period will not end with respect to an MDPP beneficiary who begins to receive MDPP services virtually within 90 days after the occurrence of an 1135 waiver event that CMS determines is likely to disrupt the furnishing of in-person MDPP services.

CMS remains mindful of the potential for abuse with beneficiary incentives, and in the absence of any continued direct contact with the MDPP beneficiary for 90 days during an applicable 1135 waiver event, the agency does not believe that the MDPP supplier should be permitted to furnish additional beneficiary engagement incentives. However, the existing definition of engagement incentive period specifies that the period begins "when an MDPP supplier furnishes any MDPP service to an MDPP eligible beneficiary." Accordingly, even if an MDPP beneficiary's engagement incentive period ends during an applicable 1135 waiver event due to lack of direct contact with the MDPP supplier, the beneficiary would begin a new engagement incentive period consistent with the existing definition when he or she resumes or restarts MDPP services

CMS did not finalize the proposal to add a requirement governing the provision of an in-kind item or service as a beneficiary engagement incentive during the COVID-19 PHE or the applicable 1135 waiver event.

APPENDIX A

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
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	$192	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%
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%

(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
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%	8%
VASCULAR SURGERY	$1,293	-2%	-4%	0%	-6%
TOTAL	**$97,008**	**0%**	**0%**	**0%**	**0%**

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