Key Takeaways from the CY 2022 Medicare Physician Fee Schedule Proposed Rule (Non-QPP)

Comments due September 13, 2021 by 5:00 p.m. EDT

On July 13, 2021, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2022 Medicare Physician Fee Schedule (PFS) Proposed Rule, available here.[1] The CMS fact sheet is available here. Key takeaways from the CY 2022 PFS Proposed Rule that do **not** relate to the QPP are summarized below. Please see the end of this document for a glossary of key terms.

Global Payment Provisions:

The Medicare PFS proposed rule includes a 3.75% reduction to the PFS annual conversion factor (CF), which will impact the Medicare payment for the services of physicians and other billing professionals.[2] Payments are based on the relative resources typically used to furnish the service.[3] Relative value units (RVUs) are applied to each service for work, practice expense, and malpractice expense.[4] The CF affects payment for administration of drugs and biologics.[5]

The Consolidated Appropriations Act, 2021 (CAA) enacted a 3.75% increase in PFS payments for services furnished in CY 2021, reducing CY 2021 PFS cuts relating to budget neutrality adjustments and thereby providing additional support to physicians and other professionals during the COVID-19 Public Health Emergency (PHE).[6] The CY 2022 proposed conversion factor is net of a budget neutrality adjustment to account for RVU changes and the expiration of the CAA's 3.75% payment increase for CY 2021.[7]

In addition, CMS proposes a series of technical changes involving practice expense, including updating the non-physician clinical labor (wage rate) pricing for CY 2022, in conjunction with the final year of the supply and equipment pricing update.[8] The agency utilized a 4-year transition for the market-based supply and equipment pricing update, which concludes in CY 2022.[9] CMS is considering the use of a similar 4-year transition to implement the clinical labor pricing update.[10] CMS explains that "a multi-year transition could smooth out the increases and decreases in payment caused by the pricing update for affected stakeholders, promoting payment stability."[11] CMS seeks comments on the proposed updated clinical labor pricing.[12]

Key proposals from the Proposed Rule include:

- Updating the annual PFS conversion factor;
- Decreasing the practice expense (PE) RVUs for several services, including drug administration;
- Clarifying and refining payment policies for self-administered esketamine;
- Soliciting comments regarding payment rates for vaccine administration services, including in-home COVID-19 vaccine administration add-on payments;
- Developing and clarifying policies aimed at enhancing Medicare telehealth services and remote therapeutic monitoring (RTM) services;
- Clarifying and refining policies for split (or shared) evaluation and management (E/M) visits, critical care services, and services furnished by teaching physicians involving residents;
- Allowing direct payment to Physician Assistants (PAs) for professional services furnished under Part B beginning January 1, 2022;
- Requiring electronic prescribing of controlled substances under Part D using the National Council for Prescription Drug Programs (NCPDP) SCRIPT 2017071 standard by January 1, 2023;
- Updating the Open Payments Program to include an optional recertification for entities without reporting requirements and defining physician-owned distributorships, among other revisions; and
- Updating and clarifying other general Part B payment policy changes for physician services.

Key Proposed Changes in the CY 2022 PFS Proposed Rule (Non-QPP)

Policy Topic	Current Policy	CY 2022 Proposed Change
Annual PFS Conversion Factor & PFS Estimated Impact		
Annual PFS Conversion Factor	CMS finalized a conversion factor of $34.89 for CY 2021.[13] This reflects a 3.75% increase provided in the CAA for services furnished in CY 2021.[14]	**CMS would decrease the conversion factor from $34.89 to $33.58 in CY 2022.[15]** The overall payment rate update would be -3.75%.[16] This update would reflect the budget neutrality adjustment.
Drug Administration Rates	For CY 2021 drug administration rates for relevant services, please see the CY 2021 crosswalk.	CMS would decrease PE RVUs and reduce the CF in CY 2022, which would lead to overall lower payments for drug administration in CY 2022.[17] The reductions in PE RVUs may be due to system wide, redistribution effects.[18] For a crosswalk of proposed CY 2022 drug administration rates for relevant services, please see **Appendix 1**.
PFS Estimated Impact	For the CY 2021 PFS estimated impact on total allowed charges by specialty, please see the CY 2021 PFS Final Rule.[19]	For the CY 2022 PFS estimated impact on total allowed charges by specialty, please see **Appendix 2**.
Self-Administered Esketamine		
Esketamine Payment Policies	HCPCS codes G2082 and G2083 are assigned to the "All Physicians" specialty.[20] CMS expressed its intent to revise the assigned physician specialty for these codes to "General Practice," but did not for CY 2021.[21]	**CMS would maintain the "All Physicians" specialty assignment for indirect PE allocation for HCPCS codes G2082 and G2083.[22]** CMS states the proposal would help maintain payment stability consistent with the rates published in the CY 2020 PFS final rule and the CY 2021 PFS proposed rule.[23] **CMS requests comment on which specialty would be the most appropriate to use for indirect PE allocation for HCPCS codes G2082 and G2083, and input regarding the indirect costs associated with these services, relative to other services furnished by the recommended specialty.[24]**

Policy Topic	Current Policy	CY 2022 Proposed Change
		Although CMS expresses an intent to maintain payment consistency for HCPCS codes G2082 and G2083, the agency's proposed clinical labor pricing update for CY 2022 would result in G2082 and G2083 facing a decline in payment.[25] CMS seeks comments on the proposed updated clinical labor pricing.[26] The agency is considering the use of a 4-year transition to implement the update in order to promote payment stability.[27] CMS previously used this approach for the agency's market-based supply and equipment pricing update.[28]
Vaccine Administration Services		
Vaccine Administration Payment Rate	CMS maintained payment in CY 2021 for immunization administration services at CY 2019 rates, but acknowledged commenter concerns.[29]	**CMS solicits comments on how the agency should update the payment rate for administration of preventive vaccines for use on a long-term basis.[30]** CMS notes that the national payment rate for administering certain preventive vaccines (influenza, pneumococcal, and HBV) has declined more than 30% since 2015.[31]
COVID-19 Vaccine In-Home Administration	In June 2021, CMS established a new add-on payment of $35.50 for in-home administration of the COVID-19 vaccine for certain vulnerable or hard-to-reach beneficiaries.[32]	CMS requests stakeholder input on the agency's preliminary add-on payment of $35.50 for in-home COVID-19 vaccine administration for certain vulnerable or hard-to-reach beneficiaries.[33]
COVID-19 Monoclonal Antibody Products Payment	CMS currently covers monoclonal antibody products used to treat COVID-19 under the COVID-19 vaccine benefit.[34] As a result, there is no beneficiary cost sharing for these products or related administration services.[35]	CMS requests comment on the agency's approach to coverage and payment for COVID-19 monoclonal antibody products.[36]
Telehealth & Remote Services		
COVID-19 Public Health Emergency (PHE)	CMS includes certain services that were added during the PHE for COVID-19 under	**CMS proposes to allow services added to Category 3 of the Medicare telehealth list to remain on the telehealth services list until December 31, 2023.[39]**

Policy Topic	Current Policy	CY 2022 Proposed Change
Telehealth Services	Category 3 of the Medicare telehealth services list.[37] Any service added under Category 3 remains on the telehealth services list on a temporary basis through the CY in which the PHE ends.[38]	This would allow stakeholders additional time to prepare and submit data on Category 3 services to support potential permanent addition to the telehealth services list.[40]
Mental Health Telehealth Services	N/A.	**CMS proposes implementing changes related to mental health telehealth services allowed by the CAA.** The CAA removed certain telehealth geographic restrictions and added the home of the beneficiary as a permissible originating site for telehealth services furnished for the purposes of diagnosis, evaluation, or treatment of a mental health disorder on or after the end of the PHE for COVID-19.[41] The agency proposes that as condition of payment for mental health telehealth services allowed by the CAA, an in-person, non-telehealth service must be have been provided by the billing physician or practitioner within six months before the date of the telehealth service.[42] CMS proposes allowing audio-only communication technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to an established patient in their home, if the patient is not capable of, or does not consent to, the use of video technology.[43] However, the physician or practitioner must have the technical capacity to furnish two-way, audio/video telehealth services.[44]
Remote Therapeutic Monitoring (RTM)	In previous rulemaking, CMS finalized seven Remote Physiological Monitoring (RPM) codes, which include services similar to new RTM codes.[45]	CMS proposes work RVUs for five RTM codes created by the CPT Editorial Panel in October 2020.[46] The agency proposes work RVUs for new RTM CPT codes 989X1, 989X2, 989X3, 989X4, and 989X5.[47] These codes monitor health conditions (e.g.,

Policy Topic	Current Policy	CY 2022 Proposed Change
		therapy adherence), and reflect similar staff and physician work to RPM codes.[48] Unlike RPM codes, RTM codes allow non-physiologic data to be collected, and data may be self-reported (as well as digitally uploaded).[49] Additionally, nurses and physical therapists are projected to be primary billers of RTM codes.[50] However, CMS highlights certain RTM code construction issues for billing practitioners who are not physicians or non-physician practitioners and seeks stakeholder input on potential remedies.[51]
Evaluation and Management (E/M) Services		
Split (or Shared) Visits	CMS addressed billing split (or shared) visits in the agency's Medicare Claims Policy Manual.[52] However, CMS withdrew these manual provisions in May 2021 and indicated it intended to engage in rulemaking to address these visits.[53] In the interim, broader Medicare statutes and regulations continue to apply to billing split (or shared) visits.[54]	CMS proposes to define a split (or shared) visit as an E/M visit in the facility setting (i.e., an institutional setting, for which "incident to" payment is not available) that is performed in part by both a physician and a nonphysician practitioner (NPP) who are in the same group, in accordance with applicable laws and regulations.[55] The service could be billed by either the physician or NPP if furnished independently by only one of them (rather than as a split (or shared) visit).[56] Only the practitioner who performs the substantive portion of the split (or shared) visit (i.e., more than half of the total time) would bill for the visit.[57] CMS proposes requiring that the medical record identify the two individual practitioners who performed the visit, with the billing individual signing and dating the medical record.[58] The agency additionally proposes to allow physicians and NPPs to bill for split (or shared) visits for new and established patients, as well as initial and subsequent visits.[59]
Critical Care Services	CMS addressed billing critical care services in the agency's Medicare Claims	CMS proposes adopting the American Medical Association (AMA) CPT prefatory language as the definition of critical care services, and allowing

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	Policy Manual.[60] However, CMS withdrew these manual provisions in May 2021 and indicated it intended to engage in rulemaking to address these services.[61] In the interim, broader Medicare statutes and regulations continue to apply to billing critical care services.[62]	critical care services to be furnished as concurrent care to the same patient on the same day by more than one practitioner representing more than one specialty.[63] The agency also proposes restricting reporting of critical care visits with a procedure code with a global surgical period and certain other E/M visits.[64]
Teaching Physician Services	CMS allows practitioners to select the office/outpatient E/M visit level to bill.[65] Generally, more complex visits correspond with higher level codes for billing.[66] Practitioners may select visit level based on either on the total time personally spent by the reporting practitioner or medical decision making (i.e., the complexity of establishing a diagnosis and/or selecting a management option).[67]	CMS proposes clarifying when total time is used to determine the office/outpatient E/M visit level to bill, only the time that the teaching physician was present can be included.[68] Under the primary care exception (i.e., when certain services are furnished by a resident without the physical presence of a teaching physician), the agency proposes that only medical decision making can be used to select the E/M visit level.[69]
Physician Assistants (PAs)		
PA Payment	Currently, PA services are covered under Medicare Part B only when billed by the PA's employer.[70]	**The agency proposes to allow Medicare to make direct payment to PAs for professional services furnished under Part B beginning January 1, 2022.[71]**
Other Policies Impacting Medicare Part B Physician Services		
Average Sales Price Reporting (ASP)	Drug manufacturers without Medicaid drug rebate agreements can voluntarily submit ASP data to CMS, but are not required to do so under CMS regulations.[72]	The agency proposes to align its regulations with a statutory requirement that for calendar quarters beginning January 1, 2022, manufacturers must report ASP for drugs and biologicals payable under Part B, regardless of whether they have Medicaid drug rebate agreements.[73]

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Section 505(b)(2) Drug Products Codes	In CY 2021 rulemaking, CMS proposed to codify its existing policy of assigning certain 505(b)(2) drug products to existing multiple source drug codes.[74] In response to commenters requesting more detail about the proposed approach, CMS delayed adoption of the proposal for CY 2021.[75]	**CMS seeks comment on a decision framework for determining whether a section 505(b)(2) drug product corresponds to an existing multiple source drug code.[76]** This framework would be applied to 505(b)(2) drug products where a billing code descriptor for an existing multiple source code describes the product and other factors, such as the product's labeling and uses, that are similar to products that are already assigned to the code.[77] The framework is intended to be consistent with maintaining payment of similar amounts for comparable services, and with efforts to curb drug prices.[78]
ASP for Certain Self-Administered Drug Products	The Medicare Part B payment limits for a single source drug or biological is, in many cases, based on the ASP of the product.[79] Pricing information is currently reported, and considered for payment limit calculations, for all versions of products produced or distributed under an applicable FDA approval.[80] This includes self-administered versions that are not covered under Part B.[81]	**CMS proposes a methodology for the determination of ASP for certain self-administered drug products.** The Office of Inspector General (OIG) must conduct periodic studies for non-covered, self-administered versions of drugs or biologicals that should be excluded from the determination of the payment amount.[82] CMS is permitted to apply a payment limit calculation methodology (the "lesser of" methodology) to applicable billing codes, if deemed appropriate.[83] The Medicare payment limit for the drug or biological billing code would be the lesser of the payment limit determined using the current methodology (i.e., the calculation includes the ASPs of the self-administered versions), or the payment limit calculated after excluding the non-covered, self-administered versions.[84] CMS proposes application of the "lesser of" methodology to drug and biological products that may be identified by future OIG reports.[85]
Electronic Prescribing of Schedule II, III, IV, and V Controlled Substances Under Part D		
Electronic Prescribing Standard	Prescribers must use the National Council for Prescription Drug Programs (NCPDP) SCRIPT 2017071 standard when conducting e-prescribing for covered Part	CMS proposes that prescribers must conduct e-prescribing of Schedule II, III, IV, and V controlled substances under Part D using the NCPDP SCRIPT 2017071 standard by **January 1, 2023**, except for prescriptions written for

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	D drugs for Part D eligible individuals.[86] CMS requires use of this standard for e-prescribing for all Schedule II, III, IV, and V controlled substances by January 1, 2022.[87]	beneficiaries in a long-term care (LTC) facility.[88] This proposal would delay the implementation date by one year.[89] Additionally, CMS proposes to extend the deadline for Part D controlled substance prescriptions written for beneficiaries in LTC facilities (excluding beneficiaries who are residents of nursing facilities and whose care is provided under Part A of the benefit) from January 1, 2022 to January 1, 2025.[90] Esketamine is a Schedule III controlled substance, and therefore prescribers of esketamine would need conduct electronic prescriptions using the NCPDP SCRIPT standard by these proposed deadlines. CMS requests comments on this proposal.[91]
Electronic Prescribing Compliance Threshold	N/A.	**CMS proposes a compliance threshold for the electronic prescribing of controlled substances requirement.[92]** Specifically, 70% of all prescribing under Part D for Schedule II, III, IV, and V controlled substances would need to be done electronically per calendar year.[93] However, any prescriptions issued while a prescriber falls within an exception or a waiver are excluded from the percentage.[94] CMS proposes three classes of exceptions/waivers: o Prescribers who issue 100 or fewer Part D controlled substance prescriptions per year.[95] o Prescriptions issued when the prescriber and dispensing pharmacy are same entity.[96] o Cases of recognized emergencies and extraordinary circumstances.[97]

Policy Topic	Current Policy	CY 2022 Proposed Change
Open Payments Financial Transparency Program		
Open Payments Program Updates	The Open Payments Financial Transparency Program requires drug and device manufacturers and group purchasing organizations to report payments or transfers of value to physicians, teaching hospitals, and other providers to CMS.[98]	**The agency proposes updates to the Open Payments Program,** including creation of an optional recertification for entities without reporting requirements and defining physician-owned distributorships, among other changes.[99]
National Coverage Determinations (NCDs)		
NCD Updates	CMS periodically identifies and removes NCD items and services that no longer contain clinically pertinent and current information, or that involve items or services that are not used frequently.[100] CMS selected and removed six older NCDs in CY 2021 rulemaking.[101]	**The agency proposes to remove two NCDs that may be outdated:** o 180.2, Enteral and Parenteral Nutritional Therapy[102] o 220.6, Positron Emission Tomography (PET) Scans[103] Under the proposal, these items and services would no longer be automatically covered.[104] Instead, coverage decisions would be up to the Medicare Administrative Contractors (MACs).[105]

Commenting on the Proposed Rule

- The deadline for submitting comments is **5:00 p.m. EDT on September 13, 2021.** Commenters must refer to file code CMS-1751-P when commenting on the Proposed Rule. Interested stakeholders can submit comments electronically by visiting Regulations.gov. Alternatively, comments can be submitted by mail to the following addresses:

Regular Mail
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
P.O. Box 8016
Baltimore, MD 21244-8016

Express or Overnight Mail
Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1751-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Glossary

Key Term	Definition
CPT	Current Procedural Terminology (CPT) is a medical code set that is developed by the American Medical Association and is used by physicians, hospitals, outpatient facilities, laboratories, and other health care professionals to describe the procedures and services they perform.[106]
E/M	Evaluation and management (E/M) codes classify services provided by physicians and other practitioners in evaluating patients and managing their medical care. E/M codes vary based on level of complexity, site of service, and whether the patient is new or established.[107]
WAC	Wholesale Acquisition Cost (WAC) is the manufacturer's published "list price" for a drug to wholesalers or direct purchasers. WAC is reported in wholesale price guides or other publications of drug pricing data. It does not include discounts or rebates.[108]
Conversion Factor	CMS uses a conversion factor to convert national relative value units (RVUs) into payment rates. For each service, RVUs are established for physician work, practice expense, and malpractice insurance. These RVUs are adjusted for geographic cost variations and multiplied by a conversion factor to convert them into payment rates.[109]
Budget Neutrality Adjustment	The Social Security Act prohibits any increase or decrease in relative value units (RVUs) from causing the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS makes adjustments to the conversion factor to preserve budget neutrality.[110]
505(b)(2) Drug Product	A 505(b)(2) application is a New Drug Application (NDA) that contains full reports of investigations of safety and effectiveness, but at least some of the information required for approval comes from studies not conducted by or for the application and for which the applicant has not obtained a right of reference or use.[111]

Appendix 1

Proposed 2022 Medicare Coding & Payment* for Drug Administration Services under the Physician Fee Schedule

CPT® Codes	Description	2021 Final $ Rates[1]	2022 *Proposed* $ Rates[2]
	Hydration		
96360	IV infusion, hydration, 31 minutes to 1 hour	36.29	31.75
96361	IV infusion, hydration; each additional hour	13.96	12.56
	Therapeutic, Prophylactic, and Diagnostic Infusions infusion		
96365	IV infusion, for therapy/ prophylactic/ diagnostic, initial, up to 1 hr	73.62	64.90
96366	IV infusion for therapy/prophylaxis/diagnosis; each additional hour	22.33	20.94
96367	Additional sequential infusion of a new drug/substance, up to 1 hr	32.10	28.61
96368	Concurrent infusion	21.28	19.89
96379	Unlisted therapeutic, prophylactic or diagnostic intravenous or intra-arterial injection or infusion	N/A[3]	N/A[3]
	Chemotherapy & complex drug/biologic infusions		
96413	Chemo administration, intravenous infusion; up to 1 hour, single or initial substance or drug	148.30	128.76
96415	Chemo administration, intravenous infusion; each additional hour	31.40	28.26
96417	Chemo iv; each additional sequential infusion (different substance/drug) up to 1 hour	71.88	63.51
96422	Chemotherapy, intra-arterial infusion technique up to 1 hour	180.05	156.32
96423	Chemotherapy, intra-arterial infusion technique; each additional hour	82.70	73.97
96416	Chemo, initiation of prolonged iv infusion (>8 hrs) requiring portable/ implantable pump	147.25	126.31
	IV push		
96374	Therapeutic, prophylactic or diagnostic intravenous push; single or initial substance or drug	41.87	36.99
96375	Therapeutic, prophylactic or diagnostic iv push, new substance/drug	17.10	15.70
96373	Therapeutic, prophylactic or diagnostic injection, intra-arterial	18.49	19.54
96409	Chemo administration, intravenous push, single or initial substance/drug	113.40	100.49
96411	IV push, each additional chemo substance/drug	62.11	54.78
96420	Chemotherapy, intra-arterial, push technique	115.50	102.59
	Injections		
96372	Therapeutic, prophylactic or diagnostic injection, sc or im	14.31	15.00
96377	Application on-body injector	20.24	18.84
96401	Chemo administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	82.35	72.23
96402	Chemo administration, subcutaneous or intramuscular; hormonal anti-neoplastic	33.15	37.34
	Other chemotherapy administration codes		
96425	Chemo initiation of prolonged ia infusion (>8 hrs) requiring use of a portable/ implantable pump	192.96	168.88
96549	Unlisted chemotherapy procedure	N/A[3]	N/A[3]
96405	Chemo intralesional, up to and including 7 lesions	87.58	81.65
96406	Chemo intralesional, more than 7 lesions	136.08	128.06

Collected in 08/21 and is subject to change. This information does not provide advice or guarantee coverage or payment. Legal requirements and plan information can be updated frequently. We strongly recommend contacting the plan for more information about current coverage, restrictions, or prerequisites that may apply.

*** NOTE:** All reimbursement is presented as national rates, without application of geographic adjustment factors (GPCI). Actual provider payment rates will vary according to the geographic location of the practice. The rates displayed have not been adjusted for any impact of sequestration.

[1] The "2021 Final Rates" are calculated using: 1) the 2021 conversion factor (CF) of 34.8931, as per *CMS-1734-F. Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Final Rule,* 85 Fed. Reg. 84,472 (Dec. 28, 2020), as modified by the Consolidated Appropriations Act, 2021, available at: https://www.cms.gov/medicare/medicare-fee-for-service-payment/physicianfeesched; and 2) the 2021 total RVUs, comprised of: work RVU (wRVU), non-facility (NF) Practice Expense RVU (peRVU), and malpractice RVU (mRVU) weights, per RVU21B, April 2021 Release, available at: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-relative-value-files/rvu21b
Calculated dollar amounts reflect national rates before geographic adjustment.

[2] The "2022 Proposed Rates" are calculated using: 1) the proposed 2022 conversion factor (CF) of 33.5848; and 2) proposed 2022 total RVUs, comprised of: work RVU (wRVU), non-facility (NF) Practice Expense RVU (peRVU), and malpractice RVU (mRVU) weights, as published in *CMS-1751-P. Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Proposed Rule,* displayed July 13, 2021 and Addendum B, both available at: https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-p
Calculated dollar amounts reflect national rates before geographic adjustment.

[3] Contractor-priced code. Contractors establish RVUs and payment amounts for these services.

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Appendix 2
CY 2022 PFS Estimated Impact on Total Allowed Charges by Specialty[112]

Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Allergy/Immunology	$220	0%	-2%	0%	-2%
Anesthesiology	$2,755	0%	1%	0%	1%
Audiologist	$58	0%	-1%	0%	-1%
Cardiac Surgery	$203	0%	-1%	0%	-1%
Cardiology	$6,119	0%	-1%	0%	-2%
Chiropractic	$617	0%	0%	0%	0%
Clinical Psychologist	$814	0%	0%	0%	0%
Clinical Social Worker	$873	0%	0%	0%	0%
Colon And Rectal Surgery	$144	0%	0%	0%	0%
Critical Care	$367	0%	0%	0%	0%
Dermatology	$3,454	0%	-1%	0%	0%
Diagnostic Testing Facility	$682	0%	0%	0%	0%
Emergency Medicine	$2,525	0%	0%	0%	0%
Endocrinology	$506	0%	2%	0%	2%
Family Practice	$5,725	0%	2%	0%	2%
Gastroenterology	$1,476	0%	0%	0%	0%
General Practice	$368	0%	1%	0%	2%
General Surgery	$1,738	0%	0%	0%	0%
Geriatrics	$175	0%	1%	0%	2%
Hand Surgery	$222	0%	2%	0%	2%
Hematology/Oncology	$1,737	0%	-2%	0%	-2%
Independent Laboratory	$552	0%	-2%	0%	-2%
Infectious Disease	$639	0%	-1%	0%	-1%
Internal Medicine	$9,906	0%	1%	0%	1%
Interventional Pain Mgmt	$900	0%	1%	0%	1%

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Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Interventional Radiology	$480	0%	-9%	0%	-9%
Multispecialty Clinic/Other Phys	$138	0%	0%	0%	0%
Nephrology	$2,303	0%	0%	0%	0%
Neurology	$1,354	0%	0%	0%	1%
Neurosurgery	$708	0%	0%	0%	0%
Nuclear Medicine	$50	0%	-2%	0%	-2%
Nurse Anes / Anes Asst	$2,092	0%	1%	0%	1%
Nurse Practitioner	$5,288	0%	1%	0%	1%
Obstetrics/Gynecology	$558	0%	1%	0%	1%
Ophthalmology	$4,365	0%	0%	0%	0%
Optometry	$1,108	0%	0%	0%	1%
Oral/Maxillofacial Surgery	$70	0%	-4%	0%	-4%
Orthopedic Surgery	$3,273	0%	1%	0%	1%
Other	$52	0%	-1%	0%	-1%
Otolarngology	$1,037	0%	-1%	0%	-1%
Pathology	$1,061	0%	-1%	0%	-1%
Pediatrics	$55	0%	1%	0%	1%
Physical Medicine	$1,030	0%	0%	0%	0%
Physical/Occupational Therapy	$3,976	-1%	-1%	0%	-2%
Physician Assistant	$2,810	0%	1%	0%	1%
Plastic Surgery	$319	0%	1%	0%	1%
Podiatry	$1,847	0%	1%	0%	1%
Portable X-Ray Supplier	$84	0%	10%	0%	10%
Psychiatry	$1,040	0%	1%	0%	1%
Pulmonary Disease	$1,471	0%	0%	0%	0%
Radiation Oncology And Radiation Therapy Centers	$1,660	0%	-5%	0%	-5%
Radiology	$4,397	0%	-2%	0%	-2%
Rheumatology	$541	0%	-1%	0%	-1%

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Specialty	Allowed Charges (mil)	Impact of Work RVU Changes	Impact of PE RVU Changes	Impact of MP RVU Changes	Combined Impact
Thoracic Surgery	$302	0%	-1%	0%	-1%
Urology	$1,677	0%	0%	0%	0%
Vascular Surgery	$1,144	0%	-8%	0%	-8%
Total	$89,065	0%	0%	0%	0%
The "Combined Impact" column may not equal the sum of the "Impact of Work RVU Changes," "Impact of PE RVU Changes," and "Impact of MP RVU Changes" columns due to rounding.					

[1] Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; Provider and Supplier Prepayment and Post-payment Medical Review Requirements, Proposed Rule, 86 Fed. Reg. 39,104 (July 23, 2021), *available at* https://www.govinfo.gov/content/pkg/FR-2021-07-23/pdf/2021-14973.pdf [hereinafter "PFS Proposed Rule"].

[2] *See id.* at 39,106, 39,530. This percentage change includes the expiration of the payment increase provided for CY 2021 by the Consolidated Appropriations Act, 2021. *Id.* at 39,529-30.

[3] *Id.* at 39,106-07.

[4] *Id.*

[5] *Id.*; *see* CMS, CY 2022 PFS Proposed Rule Addendum B (July 23, 2021), https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-p.

[6] *See* Medicare Program; CY 2021 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies, 85 Fed. Reg. 84,472, 85,000 (Dec. 28, 2020); Consolidated Appropriations Act, 2021, Pub. L. No. 116-260, Division N, Title I, § 101(a).

[7] PFS Proposed Rule at 39,529-30.

[8] *See id.* at 39,113-23.

[9] *Id.* at 39,123.

[10] *Id.*

[11] *Id.*

[12] *Id.* at 39,121.

[13] *Id.* at 39,530.

[14] *Id.* at 39,529.

[15] *Id.* at 39,530.

[16] *See id.* at 39,529-30. This percentage change includes the expiration of the payment increase provided for CY 2021 by the Consolidated Appropriations Act, 2021. *Id.*

[17] *See* CMS, CY 2022 PFS Proposed Rule Addendum B (July 23, 2021), https://www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-p; *see* PFS Proposed Rule at 39,529-30.

[18] *See, e.g.,* PFS Proposed Rule at 39,123.

[19] 85 Fed. Reg. 85,001-02.

[20] PFS Proposed Rule at 39,115.

[21] *Id.*

[22] *Id*.

[23] *Id.*

[24] *Id.*

[25] *Id.*; *see id.* at 39,123.

[26] *Id.* at 39,121.

[27] *Id.*

[28] *Id.* at 39,123.

[29] *Id.* at 39,220-21.

[30] *Id.* at 39,223.

[31] *Id.* at 39,221-22.

[32] *Id.* at 39,224.

[33] *Id.* at 39,225.

[34] *Id.* at 39,226.

[35] *Id.*

[36] *Id.* at 39,227.

[37] *Id.* at 39,130.

[38] *Id.* at 39,136.

[39] *Id.* at 39,137.

[40] *Id.*

[41] *Id.* at 39,145.

[42] *Id.* at 39,146.

[43] *Id.* at 39,148.

[44] *Id.*

[45] *Id.* at 39,173.

[46] *Id.* at 39,173-74.

[47] *Id.* at 39,174.

[48] *Id.* at 39,173-74.

[49] *Id.* at 39,174.

[50] *Id.*

[51] *Id.*

[52] *Id.* at 39,204.

[53] *Id.*

[54] *Id.*

[55] *Id.* at 39,204, 39,590.

[56] *Id.* at 39,590.

[57] *Id.* at 39,205.

[58] *Id.* at 39,207.

[59] *Id.* at 39,206.

[60] *Id.* at 39,207.

[61] *Id.*

[62] *Id.*

[63] *Id.* at 39,208-09.

[64] *Id.* at 39,208.

[65] *Id.* at 39,211.

[66] CMS, Evaluation and Management Services Guide (Feb. 2021) at 7, https://www.cms.gov/outreach-and-education/medicare-learning-network-mln/mlnproducts/downloads/eval-mgmt-serv-guide-icn006764.pdf.

[67] *Id.* at 15; PFS Proposed Rule at 39,211.

[68] PFS Proposed Rule at 39,212.

[69] *Id.*

[70] *Id.* at 39,213.

[71] *Id.*

[72] *Id.* at 39,240.

[73] *Id.* at 39,241.

[74] 85 Fed. Reg. 84,815.

[75] *Id.*

[76] PFS Proposed Rule at 39,247.

[77] CMS, Fact Sheet; Calendar Year (CY) 2022 Medicare Physician Fee Schedule Proposed Rule (July 13, 2021), https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-proposed-rule.

[78] *Id.*

[79] PFS Proposed Rule at 39,243.

[80] *Id.*

[81] *Id.*

[82] *Id.* at 39,244; *see* 42 U.S.C. § 1395w-3a(g)(1).

[83] PFS Proposed Rule at 39,244.

[84] *Id.*

[85] *Id.*

[86] *Id.* at 39,327.

[87] *Id.*

[88] *Id.* at 39,329.

[89] *Id.*

[90] *Id.*

[91] *Id.*

[92] *Id.* at 39,330.

[93] *Id.*

[94] *Id.*

[95] *Id.* at 39,330-31.

[96] *Id.* at 39,330.

[97] *Id.* at 39,331-32.

[98] *Id.* at 39,333-34.

[99] *Id.* at 39,334-35.

[100] *Id.* at 39,255.

[101] 85 Fed. Reg. 84,802.

[102] *Id.* at 39,255.

[103] *Id.*

[104] *Id*.

[105] *Id.*

[106] AAPC, Medical Coding, What is CPT?, *available at* https://www.aapc.com/resources/medical-coding/cpt.aspx (last accessed July 20, 2021).

[107] 85 Fed. Reg. 84,548.

[108] 42 U.S.C. § 1395w–3a(c)(6)(B).

[109] PFS Proposed Rule at 39,106.

[110] *Id.* at 39,107.

[111] Federal Food, Drug, and Cosmetic Act § 505(b)(2); FDA, Determining Whether to Submit an ANDA or a 505(b)(2) Application (May 2019) at 2, *available at* https://www.fda.gov/media/124848/download.

[112] PFS Proposed Rule at 39,531-32.