SIR Summary of 2021 Proposed Medicare Physician Fee Schedule (MPFS)

On Aug 3, 2020, the Centers for Medicare & Medicaid Services (CMS) published the proposed rule for CY 2021 CMS Medicare Physician Fee Schedule (MPFS). The proposals to update payment policies, payment rates, and quality provisions for services furnished under the Medicare Physician Fee Schedule (PFS) on or after Jan 1, 2021. Under the current proposal, interventional radiology services will see a 9% cut in reimbursement, and radiology overall will see an 11% reduction. (see appendix A at the end of this document.). The proposed CY 2021 PFS conversion factor is $32.26, a decrease of $3.83 from the CY 2020 PFS conversion factor of $36.09. SIR plans on providing addressing our concerns with these proposed changes. For a quick review of the upcoming changes, please review this SIR summary along with the Fact Sheet for CY 2021 MPFS. Comments are due to CMS by Oct 5, 2020. **Planned 30-day Delayed Effective Date for the Final Rule*

Payment Provisions

CY 2021 PFS Rate Setting – The proposed CY 2021 PFS conversion factor is $32.26, a decrease of $3.83 from the CY 2020 PFS conversion factor of $36.09.

CMS accepted the RUC recommended work RVU for the following:

- 0.83 wRVU for CPT code 75984, which is for change of percutaneous tube or drainage catheter with contrast monitoring (e.g., genitourinary system, abscess) radiological supervision and interpretation
- 1.05 wRVU for CPT code 75820 (Venography, extremity, unilateral, radiological supervision, and interpretation) and 1.48 wRVU for CPT code 75822 (Venography, extremity, bilateral, radiological supervision and interpretation)

CMS did not accept the RUC recommendations for specific IR services; therefore, there will be proposed decreased values for following IR services:

- RUC recommended an increase to 4.00 wRVUs for the aggregated value for CPT code 32405 (Biopsy, lung or mediastinum, percutaneous needle); and 77012 (Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation. However, CMS disagreed with the RUC recommendation and is proposing a work RVU of 3.18 for the sum of the work.

For more details on practice expenses, please review appendix B in at the end of this document.

Medicare Telehealth and Other Services Involving Communications Technology – CMS is proposing several changes to the Medicare telehealth services list. For CY 2021, we are proposing to add the following list of services to the Medicare telehealth list on a Category 1 basis. Services added to the Medicare telehealth list on a Category 1 basis are like services already on the telehealth list: For more detail, please see appendix C at the end of this document.

Payment for Evaluation and Management (E/M) Services - 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 Pandemic. Effective Jan 1, 2021, CMS will adopt the CPT guidelines to report office visits based on either medical decision making or physician time. Budget neutrality adjustments to account for changes in RVUs were applied to the fee schedule.

Global Surgery Codes - For CY 2021, the AMA RUC made a recommendation to revalue these services, along with their recommendations to revalue the 10- and 90- day global surgical packages, to account for increases in the values of office/outpatient E/M visits. In the CY 2020 PFS final rule, CMS decided not to make changes to the valuation of 10- and 90- day global surgical packages to reflect changes made to values for the office/outpatient E/M visit codes while CMS continues to collect and analyze the data on the number and level of office/outpatient E/M visits that are actually being performed as part of these services. This proposed rule does not change that CY 2020 CMS decision. CMS did, however, revalue several services that are analogous to office/outpatient E/M visits (i.e., maternity, ESRD, TCM).

HCPCS code GPC1X - CMS is moving forward with the implementation of HCPCS code GPCIX, despite concerns from the medical specialty societies. CMS is soliciting public comments on additional, more specific information regarding what aspects of the definition of HCPCS add-on code GPC1X are unclear, how CMS might address those concerns, and how CMS might refine our utilization assumptions for the code.

Prolonged Office/Outpatient E/M Visits (CPT code 99XXX) - CMS is proposing that when the time of the reporting physician or NPP is used to select office/outpatient E/M visit level, CPT code 99XXX could be reported when the maximum time for the level 5 office/outpatient E/M visit is exceeded by at least 15 minutes on the date of service.

Proposals Regarding Professional Scope of Practice and Related Issues

Supervision of Diagnostic tests by Certain Nonphysician Practitioners (NPPs) - For the duration of the COVID-19 PHE, if finalized on a permanent basis, effective Jan 1, 2021, CMS proposes allowing nurse practitioners (NPs), clinical nurse specialists (CNSs), physician assistants (PAs) and certified nurse-midwives (CNMs) to supervise the performance of diagnostic tests in addition to physicians within their state scope of practice and applicable state law, provided they maintain the required statutory relationships with supervising or collaborating physicians. CMS is seeking information about the number and names of states that have licensure or scope of practice laws in place, as well as any facility-specific policies, that would impact the ability of clinicians to exercise the flexibilities CMS is proposing, to help them assess the potential impact of, or challenges for, their proposed changes. CMS is seeking public comment on whether applicable state laws, the scope of practice, and facility policies would permit practitioners to exercise the proposed flexibilities if CMS were to adopt the policies proposed, and to what extent practitioners would be permitted to exercise these proposed flexibilities, such as for all diagnostic tests or only a subset.

Medical Record Documentation - CY 2021 PFS proposed rule, CMS clarifies that physicians and NPPs, including therapists, can review and verify documentation entered into the medical record by members of the medical team for their own services that are paid under the PFS. We are also clarifying that therapy students, and students of other disciplines, working under a physician or practitioner who furnishes and bills directly for their professional services to the Medicare program, may document in the record so long as it is reviewed and verified (signed and dated) by the billing physician, practitioner, or therapist.

PFS Payment for Services of Teaching Physicians - For the duration of the COVID-19 PHE, CMS is permitting teaching physicians to use audio/video real-time communications technology to interact with the resident through virtual means, which would meet the requirement that they are present for the key portion of the service, including when the teaching physician involves the resident in furnishing Medicare Telehealth services. Additionally, during the COVID-19 PHE, Medicare also considers the services of residents that are furnished outside of the scope of their approved GME programs and furnished to inpatients of a hospital in which they have their training program as separately billable physicians' services.

Principal Care Management Services in Rural Health Clinics (RHCs) and Federally Qualified Health Clinics (FQHCs) - In the CY 2020 PFS final rule, a separate payment was established for Principal Care Management (PCM) services. For PCM services furnished on or after Jan 1, 2020, there were two new HCPCS codes, G2064, and G2065, established for comprehensive care management services of a single high-risk disease. We propose to revise §405.2464 to reflect the current payment methodology that was finalized in the CY 2020 PFS final rule and add the two new HCPCS codes, G2064, and G2065, to the general care management HCPCS code, G0511, for PCM services furnished in RHCs and FQHCs beginning Jan 1, 2021.

RHCs and FQHCs that furnish PCM services would bill HCPCS code G0511, either alone or with other payable services on an RHC or FQHC claim. The current payment rate for HCPCS code G0511 is the average of the national non-facility PFS payment rate for the RHC/FQHC care management and general behavioral health codes (CPT codes 99484, 99487, 99490, and 99491). HCPCS G2064 and G2065 would be added to G0511 to calculate a new average for the national non-facility PFS payment rate. The payment rate for HCPCS code G0511 would be updated annually based on the PFS amounts for these codes.

Rebase and Revise the FQHC Market Basket - We are proposing to rebase and revise the FQHC market basket to reflect a 2017 base year. The proposed 2017-based FQHC market basket update for CY 2021 is 2.5 percent. The proposed multifactor productivity adjustment for CY 2021 is 0.6 percent. The proposed CY 2021 FQHC payment update is 1.9 percent.

For CY 2021, CMS received invoice submissions for approximately a dozen supply and equipment codes from stakeholders as part of the third year of the market-based supply and equipment pricing update. In the case of the vascular sheath (SD136) and RF endovenous occlusion catheter (SD155) supplies, the proposed price was determined by removing the sheath or catheter from the eight submitted kit invoices and then averaging the resulting price together with the single stand-alone sheath/catheter invoice.

TABLE 7: Proposed CY 2021 Market-Based Supply and Equipment Pricing Updates

CMS CODE	Description	CMS 2020 Price	Prior CMS 2022 Price	Prior CMS 2021 Price	Updated CMS 2022 Price	Updated CMS 2021 Price
SA105	UroVysion test kit	$153.040	$129.280	$141.160	$187.490	$170.265
SD089	guidewire, hydrophilic	$39.435	$43.370	$41.403	$13.350	$26.393
SD136	vascular sheath	$36.650	$52.800	$44.725	$24.444	$30.547
SD155	catheter, RF endovenous occlusion	$637.500	$550.000	$593.750	$382.500	$510.000
EQ041	Vmax 22d and 62j (PFT equip, autobox, computer system)	$47,930.000	$47,930.000	$47,930.000	$47,406.540	$47,668.270
ER044	nuclide rod source set	$1,783.167	$2,171.333	$1,977.250	$2,081.167	$1,932.167

Update on Technical Expert Panel Related to Practice Expense - The RAND Corporation is currently studying potential improvements to CMS' PE allocation methodology and the data that underlie it. Based on the results of the TEP and RAND's other ongoing research, CMS is interested in potentially refining the PE methodology and updating the data used to make payments under the PFS. CMS believes that potential refinements could improve payment accuracy and strengthen Medicare. CMS is also interested in hosting a Town Hall meeting at a date to be determined to provide an open forum for discussion with stakeholders on our ongoing research to potentially update the PE methodology and the underlying inputs. CMS also welcomes feedback from all interested parties regarding RAND's report. CMS is not making any proposals based on this report at this time. Stakeholders are encouraged to submit feedback as part of their public comments or, if outside the public comment process.

Scope Equipment - CMS did not receive further recommendations from the Scope Equipment Reorganization. The workgroup organized by the RUC following the publication of the CY 2020 final rule. CMS remains open to the submission of additional invoices to establish individual pricing for scopes. CMS continues to welcome more data to help identify pricing for the remaining scope equipment codes that still lack invoices.

Medicare Shared Savings Programs

CMS is soliciting comments on how to potentially align the Medicare Shared Savings Program quality performance scoring methodology more closely with the Merit-based Incentive Payment System (MIPS) quality performance scoring methodology. MIPS Value Pathways (MVPs) will be a participation framework beginning with the 2021 performance period. MVPs must be established through rulemaking, and we are not proposing any MVP candidates for comment in this NPRM. As a result, MVPs will not be available for MIPS reporting until the 2022 performance period, or later. For more details on the MVP program, please review the 2021 Quality Payment Program Proposed Rule Overview Fact Sheet on the SIR economics page on the website.

Merit-based Incentive Payment Systems (MIPS) – CMS proposes to continue to incrementally adjust the performance threshold and performance category weights to meet the requirements established by

the statute. At the beginning with the sixth year of the program (2022 performance period), the performance threshold needs to be set at the mean or median of the final scores for all MIPS eligible clinicians for a prior period, the performance threshold and category weights for the 2021 performance period (which equates to the 2023 payment year):

- Performance threshold to be 50 points
- Quality performance category to be weighted at 40% (5% decrease from PY 2020)
- Cost performance category to be weighted at 20% (5% increase from PY 2020)
- Promoting Interoperability performance category to be weighted at 25% (no change from PY 2020)
- Improvement Activities performance category to be weighted at 15% (no change from PY 2020)
- In the CY 2020 PFS Final Rule, CMS had finalized a performance threshold of 60 points for the 2021 performance period but are proposing and soliciting comment on a lower performance threshold of 50 points.
- By law, the Cost and Quality performance categories must be equally weighted at 30% beginning in the 2022 performance period.

QCDR Measure Requirements - Beginning with the 2022 performance period, QCDR measures must be fully tested at the clinician level in order to be considered for inclusion in an MVP. CMS also finalized policies in the Medicare and Medicaid Interim Final Rule with Comment (IFC) published 5/8/2020 (CMS-5531 IFC) which delayed QCDR measure requirements:

- Delaying the QCDR measure testing requirement until the 2022 performance period considering the pandemic and modifying the QCDR measure testing requirement to be two-step process that first requires face validity testing and eventually full measure testing (beta testing).
- Delaying the QCDR measure data collection requirement until the 2022 performance period considering the pandemic. QCDRs are required to collect data on a QCDR measure, appropriate to the measure type, prior to submitting the QCDR measure for CMS consideration during the self-nomination period.

Cost Performance Category - No major changes from last year's measures. SIR agrees with CMS' proposed changes which will include the following episode-based cost measures for CY 2021:

- Acute Kidney Injury Requiring New Inpatient Dialysis
- Elective Primary Hip Arthroplasty
- Femoral or Inguinal Hernia Repair
- Hemodialysis Access Creation
- Inpatient Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
- Lower Gastrointestinal Hemorrhage
- Lumbar Spine Fusion for Degenerative Disease, 1-3 Levels
- Lumpectomy, Partial Mastectomy, Simple Mastectomy
- Non-Emergent Coronary Artery Bypass Graft (CABG)
- Renal or Ureteral Stone Surgical Treatment

Measures (previously established and modified for CY 2021):

- TPCC measure

- MSPB Clinician measure (no change from CY2020)
- 18 existing episode-based cost measures
- Updates to measures: Adding telehealth services directly applicable to existing episode-based cost measures and TPCC measures.
- Updated specifications available for review on the MACRA feedback page (https://www.cms.gov/Medicare/QualityPayment-Program/Quality-Payment-Program/Give-Feedback)

Removal of Outdated National Coverage Determinations (NCDs) - We are proposing to seek stakeholder feedback to remove nine outdated or obsolete National Coverage Determinations (NCDs). Removing outdated NCDs means Medicare Administrative Contractors no longer are required to follow those outdated coverage policies when it comes to covering services for beneficiaries. The result will allow flexibility for these contractors to determine coverage for beneficiaries in their geographic areas based on more recent evidence and information.

All public comments on the proposed rules are due on Oct 1 for QPP and Oct 5, 2020, for MPFS proposed rule. SIR encourages its members to provide feedback to the proposed rule by emailing the economics team at economics@sirweb.org.

2021 CMS Proposed Rule (MPFS).pdf

2021 Fact Sheet (2) CMS Proposed Rule (MPFS).pdf

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Appendix A: SIR Summary (Proposed Rule Table 90)

TABLE 90: 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***
Total	**$96,557**	**0%**	**0%**	**0%**	**0%**
INTERVENTIONAL RADIOLOGY	$497	-3%	-5%	0%	-9%
RADIOLOGY	$5,253	-6%	-5%	0%	-11%

Appendix B: SIR Summary of Payment Provisions for IR Services

Category	RUC Recommendation	CMS' Proposed Changes
Introduction of Catheter or Stent (CPT code 75984)	The RUC recommended reviewing CPT code 75984 (Change of percutaneous tube or drainage catheter with contrast monitoring (e.g., genitourinary system, abscess) radiological supervision and interpretation) after more utilization data was available, which resulted in this service being surveyed and reviewed for the April 2019 RUC meeting.	CMS is proposing the work RVU of 0.83 as recommended by the RUC. CMS is proposing the RUC-recommended direct PE inputs for CPT code 75984 without refinement.
Lung Biopsy-CT Guidance Bundle (CPT code 324X0)	CPT codes 32405 (Biopsy, lung or mediastinum, percutaneous needle) and 77012 (Computed tomography guidance for needle placement (e.g., biopsy, aspiration, injection, localization device), radiological supervision and interpretation) were identified by the AMA through a screen of code pairs that are reported on the same day, same patient and same NPI number at or more than 75 percent of the time. The CPT Editorial Panel deleted CPT code 32405 and replaced it with 324X0 (Core needle biopsy, lung or mediastinum, percutaneous, including imaging guidance, when performed).	CMS is not proposing the RUC-recommended work RVU of 4.00, which is the survey median, because CMS believes this value somewhat overstates the increase in intensity. Although CMS do not imply that the decrease in time, when considering the aggregate time values for CPT codes 32405 and 77012, as reflected in survey values must equate to a one-to-one or linear decrease in the valuation of work RVUs, CMS believes that since the two components of work are time and intensity, significant decreases in time should be appropriately reflected in the work RVU. Intraservice and total time ratios using the aggregate time values of current CPT codes 32405 and 77012 suggest a significantly lower work RVU; however, CMS does not believe a decrease from the current aggregate value of 32405 and 77012 is warranted. CMS believes there is some overlap in physician work and time for the two current services, and that the recommended increase to 4.00 does not appropriately recognize this overlap. Therefore, CMS is proposing a work RVU of 3.18, which is the sum of the work RVUs of the two base codes. CMS is proposing the RUC-recommended direct PE inputs without refinement.
Venography (CPT codes 75820 and 75822)	The review of CPT code 75820 (Venography, extremity, unilateral, radiological supervision and interpretation) was prompted by the Relativity Assessment Workgroup Medicare utilization screen of over 20,000 claims in a year. CPT code	CMS is proposing these RUC recommended values for CPT code 75822.

	75820 currently has a work RVU of 0.70 with 14 minutes of total time. This service involves the supervision and interpretation of a contrast injection and imaging of either the upper or lower extremity. For CPT code 75820, the RUC recommends 12 minutes preservice time, 20 minutes intra-service time, 10 minutes post-service time and 42 minutes of total time. The specialty societies' survey at the 25th percentile yielded a 1.05 work RVU, and it is the RUC's recommended work value. CMS is proposing the RUC recommended value for CPT code 75820. CPT code 75822 (Venography, extremity, bilateral, radiological supervision and interpretation) was reviewed as part of the family of codes included with CPT code 75820. CPT code 75822 has a current 1.06 work RVU and 21 minutes of total time. The RUC recommended 15 minutes preservice time, 30 minutes intra-service time, 12 minutes post-service time and 57 minutes of total time, and the survey's 25th percentile work RVU of 1.48. The service is like CPT 75820, except that this CPT code is bilateral, involving the supervision and interpretation of a contrast injection and imaging of both of either the upper or lower extremities. The RUC recommended 1.48 work RVU and 57 minutes of total time for CPT code 75822.	
Updated Supply Pricing for Venous and Arterial Stenting Services	The use of the "stent, vascular, deployment system, Cordis SMART" (SA103) supply is no longer typical in CPT codes 37238 (Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; initial vein) and 37239 (Transcatheter placement of an intravascular stent(s), open or percutaneous, including radiological supervision and interpretation and including angioplasty within the same vessel, when performed; each additional vein). A new venous stent system had become the typical standard of care for these services, and they supplied ten invoices for use in pricing this supply. As such,	CMS welcomes additional information from stakeholders regarding the nature and pricing of this supply item.

	CMS is proposing to remove the SA103 supply item from CPT codes 37238 and 37239. CMS is proposing to replace it with a newly created "venous stent system" (SD340) supply at the same supply quantity. CMS is proposing a price of $1,750.00 for the venous stent system.	
Percutaneous Creation of an Arteriovenous Fistula (AVF) (HCPCS code G2170 and G2171)	For CY 2019, based on two new technology applications for arteriovenous fistula creation, CMS established two new HCPCS codes to describe the two modalities of this service. Specifically, CMS established HCPCS code C9754 (Creation of arteriovenous fistula, percutaneous; direct, any site, including all imaging and radiologic supervision and interpretation, when performed and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization, when performed)) and HCPCS code C9755 (Creation of arteriovenous fistula, percutaneous using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with radiologic supervision and interpretation, when performed) and fistulogram(s), angiography, venography, and/or ultrasound, with radiologic supervision and interpretation, when performed). The HCPCS codes CMS created were for institutional payment systems, and thus did not allow for payment for the physician's work portion of the service. Stakeholders have stated that the lack of proper coding to report the physician work associated with these procedures is problematic, as physicians are either billing an unlisted procedure code, or are billing other CPT codes that do not appropriately reflect the resource cost associated with the physician work portion of the service. Stakeholders stated that separate coding for physician payment will allow billing when the procedures are furnished in either a physician office or an institutional setting, and be paid under the respective payment systems, as appropriate.	CMS has recognized that the lack of appropriate coding for this critical physician's service has become an even greater burden given the PHE that was declared effective Jan 27, 2020 for the COVID-19 epidemic. In order to mitigate potential health risks to beneficiaries, physicians and practitioners as a result of having this procedure performed in an institutional setting, CMS have created two HCPCS G codes for percutaneous creation of an arteriovenous fistula (AVF). The codes are contractor priced and effective Jul 1, 2020. This will allow for more accurate billing and coding of a crucial physician service that could then be performed in both institutional and office settings, thus mitigating unnecessary risk to beneficiaries, physicians and practitioners caused by disease transmission. The HCPCS G codes are described as follows: • HCPCS G code G2170 (Percutaneous arteriovenous fistula creation (AVF), direct, any site, by tissue approximation using thermal resistance energy, and secondary procedures to redirect blood flow (e.g., transluminal balloon angioplasty, coil embolization) when performed, and includes all imaging and radiologic guidance, supervision and interpretation, when performed.) • HCPCS G code G2171 (Percutaneous arteriovenous fistula creation (AVF), direct, any site, using magnetic-guided arterial and venous catheters and radiofrequency energy, including flow-directing procedures (e.g., vascular coil embolization with

		radiologic supervision and interpretation, CMSn performed) and fistulogram(s), angiography, venography, and/or ultrasound, with radiologic supervision and interpretation, when performed.) CMS is proposing to maintain contractor pricing for these HCPCS codes for CY 2021. CMS is also seeking information from stakeholders on the resource costs involved in furnishing the services described by HCPCS codes G2170 and G2171 to ensure proper payment for these physician's services, for consideration in future rulemaking. CMS noted that under the Outpatient Prospective Payment System (OPPS) these services are assigned to APC 5193, which for CY 2020 has an assigned payment rate of $15,938.20.
Medical Physics Dose Evaluation (CPT code 7615X)	The CPT Editorial Panel created CPT code 7615X (Medical physics dose evaluation for radiation exposure that exceeds institutional review threshold, including report), which is a new PE-only code. Because of the high amount of clinical staff time and the fact that there are not analogous services, the PE Subcommittee requested that the specialty societies conduct a PE survey. In addition, they stated that the service is stand-alone, meaning that the medical physicist works independently from a physician and there are no elements of the PE that are informed by time from a physician work survey. Following the meeting, the specialty societies developed a PE survey, which was reviewed and approved by the Research Subcommittee.	CMS is proposing the RUC-recommended direct PE inputs for CPT code 7615X without refinement.

Appendix C: SIR Summary (Proposed Rule Table 12)

Telehealth - CMS is proposing several changes to the Medicare telehealth services list. See below:

TABLE 12: Summary of CY 2021 Proposals for Addition of Services to the Medicare Telehealth Services List

Type of Service	Specific Services and CPT Codes
1. Services we are proposing for permanent addition to the Medicare telehealth services list	• Group Psychotherapy (CPT code 90853) • Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99334-99335) • Home Visits, Established Patient (CPT codes 99347- 99348) • Cognitive Assessment and Care Planning Services (CPT code 99483) • Visit Complexity Inherent to Certain Office/Outpatient E/Ms (HCPCS code GPC1X) • Prolonged Services (CPT code 99XXX) • Psychological and Neuropsychological Testing (CPT code 96121)
2. Services we are proposing as Category 3, temporary additions to the Medicare telehealth services list.	• Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT codes 99336-99337) • Home Visits, Established Patient (CPT codes 99349-99350) • Emergency Department Visits, Levels 1-3 (CPT codes 99281-99283) • Nursing facilities discharge day management (CPT codes 99315-99316) • Psychological and Neuropsychological Testing (CPT codes 96130- 96133)
3. Services we are not proposing to add to the Medicare telehealth services list but are seeking comment on whether they should be added on either a Category 3 basis or permanently.	• Initial nursing facility visits, all levels (Low, Moderate, and High Complexity) (CPT 99304-99306) • Psychological and Neuropsychological Testing (CPT codes 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) • Initial hospital care and hospital discharge day management (CPT 99221-99223; CPT 99238- 99239) • Inpatient Neonatal and Pediatric Critical Care, Initial and Subsequent (CPT 99468- 99472; CPT 99475- 99476) • Initial and Continuing Neonatal Intensive Care Services (CPT 99477-99480) • Critical Care Services (CPT 99291-99292) • End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962) • Radiation Treatment Management Services (CPT 77427) • Emergency Department Visits, Levels 4-5 (CPT 99284-99285) • Domiciliary, Rest Home, or Custodial Care services, New (CPT 99324-99328) • Home Visits, New Patient, all levels (CPT 99341- 99345) • Initial and Subsequent Observation and Observation Discharge Day Management (CPT 99217- 99220; CPT 99224- 99226; CPT 99234-99236)