AAFP
AMERICAN ACADEMY OF FAMILY PHYSICIANS

Summary of the CY 2022 Medicare Physician Fee Schedule final rule

On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2022 Medicare Physician Fee Schedule (MPFS) final rule. This regulation also impacts the Quality Payment Program (QPP). CMS also released an accompanying fact sheet. The AAFP will thoroughly review the final rule, which is effective on January 1, 2022, except where specified otherwise in the final rule.

2022 Medicare Conversion Factor and Estimated Impact on Family Medicine

The conversion factor for 2022 is $33.59. This lower than the 2021 conversion factor of $34.89. This reduction can be primarily attributed to the expiration of a 3.75 percent increase in the 2021 conversion factor, which Congress applied via legislation in December 2020. The specialty impact estimates published by CMS do not account for the expiration of the 3.75 percent increase in the 2021 conversion factor and therefore do not reflect the expected impact on family medicine.

Clinical Labor Pricing Update

For the first time since 2002, CMS will update the clinical labor portion of practice expense relative value units (RVUs) to reflect current wage data and other clinical labor costs. The update will occur over a four-year transition period.

Telehealth Changes

CMS will retain all services previously added to the Medicare telehealth services list on a Category 3 (temporary) basis until the end of calendar year 2023. Relevant services for family physicians include:

- Domiciliary, Rest Home, or Custodial Care services, Established patients (Current Procedural Terminology (CPT) 99336-99337))
- Home Visits, Established Patient (CPT 99349-99350)
- Emergency Department Visits, Levels 1-5 (CPT 99281-99285)
- Nursing facility discharge day management (CPT 99315-99316)
- Hospital discharge day management (CPT 99238-99239)
- Subsequent Observation and Observation Discharge Day Management (CPT 99217; 99224-99226)

To implement the telehealth provisions in the Consolidated Appropriations Act of 2021, CMS will do the following, effective after the end of the COVID-19 public health emergency (PHE):

- Remove geographic restrictions for telehealth services provided to diagnose, evaluate, or treat a mental health disorder
- Add home of the patient as a permissible originating site for telehealth services for the diagnosis, evaluation, or treatment of a mental health disorder
- Require, as a condition of payment for mental health telehealth services, that the billing practitioner (or another practitioner of the same subspecialty in the same group) must have furnished an in-person service to the beneficiary within the 6-month period before the date of the initial telehealth service and at least every 12 months thereafter; exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason

documented in the patient's medical record), and more frequent visits are allowed, as driven by clinical needs on a case-by-case basis.

Also, CMS will cover audio-only telehealth services for the diagnosis, evaluation, or treatment of a mental health disorder when the following conditions are met:

- The originating site of the visit is the patient's home,
- The furnishing practitioner has the capacity to furnish the service using interactive two-way, real-time audio/video technology but instead used audio-only in an instance where the beneficiary is unable to use, does not wish to use, or does not have access to two-way audio/video technology, and
- An in-person service must be furnished within 6 months of the initial audio-only service.

CMS also finalized a requirement for the use of a new modifier for services furnished using audio-only communications.

CMS will permanently adopt coding and payment for 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).

Valuation of Specific Codes

CMS has valued multiple CPT and Healthcare Common Procedure Coding System (HCPCS) codes that are new or revised for 2022. Of most interest to family physicians will be CMS's valuation of codes for chronic care management (CCM) and principal care management (PCM). CMS accepted the work relative value units (RVUs) and direct practice expense inputs recommended by the Relative Value Scale Update Committee for all these codes, which will mean an increase in the work RVUs for each of the existing CCM codes and one of the two PCM codes, which will be converting from HCPCS codes to CPT codes.

Evaluation and Management (E/M) Visits

CMS is implementing policy changes in three areas. One relates to split (or shared) visits by a physician and a non-physician provider (NPP) who are in the same group. In the final rule, CMS establishes the following:

- Definition of split (or shared) E/M visits as E/M visits provided in the facility setting by a physician and an NPP in the same group. The visit is billed by the physician or NPP who provides the substantive portion of the visit.
- For 2022, the substantive portion can be history, physical exam, medical decision-making, or more than half of the total time (except for critical care, which can only be more than half of the total time). In 2023, CMS will define the substantive portion of the visit as more than half of the total time spent.
- Split (or shared) visits can be reported for new as well as established patients, initial and subsequent visits, and prolonged services.
- CMS requires a modifier on the claim to identify these services.

- Documentation in the medical record must identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.

Another area concerns payment for teaching physicians' services. CMS finalized and clarified that when time is used to select the office/outpatient E/M visit level, only the time spent by the teaching physician in qualifying activities, including time that the teaching physician was present with the resident performing those activities, can be included for purposes of visit level selection. Under the primary care exception, time cannot be used to select visit level; only medical decision-making may be used to select the E/M visit level.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS finalized its proposal to allow RHCs and FQHCs to bill for transitional care management and other care management services furnished for the same beneficiary during the same service period, provided all requirements for billing each code are met.

CMS also finalized its proposal to revise the current regulatory language for RHC or FQHC mental health visits to include visits furnished using interactive, real-time telecommunications technology. This change will allow RHCs and FQHCs to report and receive payment for mental health visits furnished via real-time telecommunication technology in the same way they currently do when visits take place in-person, including audio-only visits when the beneficiary is not capable of, or does not consent to, the use of video technology. CMS finalized that an in-person, non-telehealth visit must be furnished at least every 12 months for these services, although exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with the reason documented in the patient's medical record) and more frequent visits are allowed, as driven by clinical needs on a case-by-case basis.

Vaccine Administration Services

Effective January 1, 2022, CMS will pay $30 per dose for the administration of the influenza, pneumococcal and hepatitis B virus vaccines. In addition, CMS will maintain the current payment rate of $40 per dose for the administration of the COVID-19 vaccines through the end of the calendar year in which the ongoing PHE ends. Effective January 1 of the year following the year in which the PHE ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines. CMS will continue the additional payment of $35.50 for COVID-19 vaccine administration in the home under certain circumstances through the end of the calendar year in which the PHE ends.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging

CMS finalized its proposal to begin the payment penalty phase of the AUC program on the later of January 1, 2023, or the January 1 that follows the declared end of the COVID-19 PHE. Previously, the payment penalty phase of the AUC program was set to begin January 1, 2022.

Pulmonary Rehabilitation, Cardiac Rehabilitation, and Intensive Cardiac Rehabilitation

CMS finalized coverage for outpatient pulmonary rehabilitation services, paid under Medicare Part B, to beneficiaries who have had confirmed or suspected COVID-19 and experience persistent symptoms that include respiratory dysfunction for at least four weeks. Additionally, CMS extended inclusion on the Medicare telehealth services list of certain cardiac and intensive cardiac rehabilitation codes through the end of CY 2023.

Medicare Shared Savings Program (MSSP)

CMS extended the CMS Web Interface reporting option for an additional three years. For performance years 2022-2024, CMS will allow MSSP accountable care organizations (ACOs) to report either the 10 CMS Web Interface measures and administer Consumer Assessment of Healthcare Providers and Systems (CAHPS) or report the three Alternative Payment Model Performance Pathway (APP) electronic clinical quality measure (eCQM)/Merit-based Incentive Payment System (MIPS) CQMs and administer CAHPS. Beginning with the 2025 performance period and subsequent years, ACOs must report the three APP eCQM/MIPS CQMs.

CMS is freezing the quality performance standard at the 30th percentile of MIPS Quality Performance Category scores for an additional year. CMS will increase the quality performance standard to the 40th percentile beginning with the 2024 performance year. For 2022 and 2023 performance years, CMS is establishing an incentive for the quality performance standard for ACOs that report the eCQMs/MIPS CQMs.

CMS will add several codes to the list of primary care services used to assign patients to the ACO. These codes include CPT codes 99441-99445, until they are no longer payable under the MPFS.

CMS will lower the repayment mechanism amounts and modify the methodology used for the annual repayment amount recalculation to use more recent data.

Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

CMS finalized its proposal to allow OTPs to furnish counseling and therapy services via audio-only interaction (such as telephone calls) after the conclusion of the COVID-19 PHE in cases where audio/video communication is not available to the beneficiary, including circumstances in which the beneficiary is not capable of or does not consent to the use of devices that permit a two-way audio/video interaction, provided all other applicable requirements are met. CMS also finalized a requirement that OTPs use a service-level modifier for audio-only services billed using the counseling and therapy add-on code.

Additionally, to avoid a significant decrease in the payment amount for methadone that could negatively affect access to methadone for beneficiaries receiving services at OTPs, CMS is issuing an interim final rule with comment to maintain the payment amount for methadone at the CY 2021 rate for the duration of CY 2022. CMS is also seeking comment on OTP utilization patterns for methadone, particularly, the frequency with which methadone oral concentrate is used compared to methadone tablets in the OTP setting, including any applicable data on this topic.

Requirement for Electronic Prescribing for Controlled Substances (EPCS) for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan

Section 2003 of the SUPPORT Act requires electronic prescribing of controlled substances (EPCS) for schedule II, III, IV, and V controlled substances covered through Medicare Part D. In December 2020, CMS implemented the first phase of this mandate by naming the standard that prescribers must use for EPCS transmissions and delaying compliance actions until January 1, 2022. In the final rule, CMS is implementing the second phase of this mandate by finalizing certain exceptions to the EPCS requirement. An exception will apply if a prescriber meets any of the following:

- the prescriber and dispensing pharmacy are the same entity;

- the prescriber issues 100 or fewer controlled substance prescriptions for Part D drugs per calendar year; and
- the prescriber is in the geographic area of an emergency or disaster declared by a federal, state, or local government entity; or
- the prescriber has been granted a CMS-approved waiver based on extraordinary circumstances, such as technological failures, cybersecurity attacks, or another emergency.

CMS is allowing prescribers to request a waiver where circumstances beyond the prescriber's control prevent the prescriber from being able to electronically prescribe controlled substances covered by Part D. Also, CMS is delaying the start date for compliance actions to January 1, 2023. CMS is also delaying the start date for compliance actions for Part D prescriptions written for beneficiaries in long-term care facilities to January 1, 2025. CMS will initially enforce compliance by sending compliance letters to prescribers violating the EPCS mandate.

Quality Payment Program (QPP)

CMS is implementing several changes to the traditional MIPS track of the QPP.

Quality category:
CMS is maintaining the data completeness criteria threshold of 70 percent for the 2022 and 2023 performance periods. CMS originally proposed to increase the threshold to 80 percent for the 2023 performance period.

Cost category:
CMS is adding five new episode-based cost measures, including two chronic condition episodes (melanoma resection, colon and rectal resection, sepsis, asthma/chronic obstructive pulmonary disease, and diabetes).

Promoting Interoperability (PI) Category:
CMS will require eligible clinicians (ECs) to report or claim an applicable exclusion the Immunization Registry Reporting and Electronic Case Reporting measures. However, CMS is establishing a fourth exclusion criteria for Electronic Case Reporting such that practices using certified electronic health record technology that is not certified to the electronic case reporting criterion prior to the selected performance period may claim an exclusion for the measure and not be penalized. CMS is also adding a new Safety Assurance Factors for EHR Resilience Guides measure that would require an eligible clinician (EC) to attest to conducting an annual self-assessment using the High Priority Practice Guide.

Beginning with the 2022 performance period, CMS will apply automatic reweighting of the promoting interoperability category for small practices (15 or fewer ECs). The category's weight will be redistributed to the other performance categories.

Scoring Policies:

After analyzing data, CMS determined it can establish reliable benchmarks using data from the 2020 performance year. As such, CMS will develop historical benchmarks for the 2022 performance period, using data submitted for the 2020 performance period.

Beginning with performance year 2022, CMS is establishing a floor for quality measures in their first two years in the MIPS program. Measures in their first year will have a seven-point floor. Measures in their second year will have a five-year floor. Measures only qualify for the scoring floor if a performance

period benchmark can be established, and data completeness and case minimum are met. CMS is removing bonus points for reporting additional high priority measures and for measures submitted using end-to-end electronic reporting. CMS will retain the three-point floor for each measure that can be reliably scored against a benchmark and remove special scoring policies for measures that do not have a benchmark. CMS intends to remove the three-point scoring floor starting with the 2023 performance year (except for small practices).

CMS will continue to double the complex patient bonus for the 2021 performance year. Beginning in 2022, CMS will modify the application of the complex patient bonus to better target ECs who treat a higher caseload of more complex and high-risk patients. The complex patient bonus will have a 10-point cap.

For the 2022 performance period, the performance threshold will be 75 points, and the exceptional performance threshold will be 89 points.

The performance category weights for the 2022 performance period will be:

- Quality – 30%
- Cost – 30%
- Improvement Activities – 15%
- Promoting Interoperability – 25%.

The maximum payment adjustment will be ±9 percent.

CMS introduces MIPS Value Pathways (MVPs) and confirms its intent to begin transitioning to MVPs in the 2023 MIPS performance year. MVP Participants will include individual clinicians, single specialty groups, multispecialty groups, subgroups, and alternative payment model entities assessed on an MVP for all MIPS performance categories. Beginning in 2026, multispecialty groups must form subgroups to report MVPs.

MVPs are designed to allow for a more cohesive participation experience by connecting activities and measures that are relevant to a specialty, medical condition, or episode of care from the four MIPS performance categories. MVPs would include the PI performance category and population health claims-based measures as foundational elements, along with relevant measures and activities for the quality, cost, and improvement activities performance categories.

To report an MVP, an MVP Participant register for the MVP (and as a subgroup if applicable) between April 1 and November 30 of the performance year. The seven MVPs for the 2023 performance year align with the following clinical topics: rheumatology, stroke care and prevention, heart disease, chronic disease management, lower extremity joint repair (e.g., knee replacement), emergency medicine, and anesthesia.

Following the release of the final rule, CMS announced that it would automatically apply the MIPS extreme and uncontrollable circumstances (EUC) policy for the 2021 performance year. The EUC policy will apply to eligible clinicians who are allowed to participate in MIPS as individuals. It will not apply to groups, virtual groups, or alternative payment model entities. You can find more information on the EUC policy here.