

CY 2022 Medicare Physician Fee Schedule Proposed Rule: What Physicians Need to Know

The Calendar Year (CY) 2022 Medicare Physician Fee Schedule (MPFS) was released on July 13, 2021 by the Centers for Medicare & Medicaid Services (CMS). The annual payment rule sets policy for physicians participating in the Medicare program and makes updates to the Quality Payment Program. AAOS will submit formal comments to CMS and appreciates feedback from members ahead of the September 13, 2021 deadline. Then the final rule will likely be released in November, and the majority of the regulations will take effect on January 1, 2022.

Payment Changes

The conversion factor, which is the primary factor determining increases or decreases to overall payment rates in the physician fee schedule, will be reduced from \$34.89 to \$33.58 (-3.75%). This change is largely a result of the planned expiration of the 3.75% increase that was implemented through congressional action at the end of 2020 in the Consolidated Appropriations Act. The estimated combined impact of the work, practice expense, and malpractice RVUs and the expiration of the 3.75% increase from Congress will be a 2.7% total decrease to the 2022 allowed charges for orthopedic surgery.

AAOS is actively working across the legislative and regulatory landscape to prevent this 3.75% cut as well as other cuts to Medicare reimbursements scheduled to take effect in 2022.

A stakeholder submitted CPT code 22551 (*Fusion of spine bones with removal of disc at upper spinal column, anterior approach, complex*) “and common related services” as potentially misvalued. The stakeholder believes that CMS has an interest in reviewing associated anterior cervical discectomy and fusion (ACDF) procedures as well and suggests that CPT code 22551 “and common related services” can result in cumulative RVUs that do not sufficiently reflect physician work, time, or outcomes.

CMS is proposing to update the policy for split/shared evaluation and management (E/M) visits in the facility setting. When an E/M visit is performed by both a physician and a non-physician practitioner (NPP) who are in the same group, the provider who performed the substantive portion of the visit will be the one who bills for it. **The substantive portion will be defined based on time,** and the below list includes what would count toward that time:

- Preparing to see the patient (for example, review of tests)

- Obtaining and/or reviewing separately obtained history
- Performing a medically appropriate examination and/or evaluation
- Counseling and educating the patient/family/caregiver
- Ordering medications, tests, or procedures
- Referring and communicating with other health care professionals (when not separately reported)
- Documenting clinical information in the electronic or other health record
- Independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver
- Care coordination (not separately reported)

Practitioners would **not** count time spent on the following:

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

CMS is proposing to implement a provision of the Consolidated Appropriations Act (2020) which **grants the Medicare program the authority to allow Physician Assistants to bill directly** for services that they furnish under Part B.

Telehealth Extensions

Separate from the temporary expansions to telehealth implemented in response to COVID-19, CMS has a system of dividing requests for additions to the telehealth services list into two categories: Category 1 requests are for adding services that are similar to professional consultations and office visits; Category 2 requests are for services that are not similar to those already approved for telehealth by Medicare.

The Category 3 list is for adding services to the Medicare telehealth list on a temporary basis following the end of the public health emergency. **CMS is proposing that services listed in Category 3 be retained until the end of CY 2023.** This will allow sufficient time to gather data of utilization and input from stakeholders prior to adding them permanently through rulemaking under Categories 1 or 2.

Examples of Category 3 HCPCS codes: Hospital Inpatient care, per day, for the evaluation and management of a patient (99221, 99222, 99223); Office/Outpatient services, telephone

evaluation and management (99441, 99442, 99443); and Observation care services for initial observation or inpatient hospital care (99218, 99219, 99220, 99234, 99235, 99236)

CMS is also finalizing a proposal to permanently adopt coding and payment for HCPCS code G2252 (*Brief communication technology-based service, e.g., virtual check-in service, 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*).

Health Policy Updates

Appropriate Use Criteria Program

CMS is proposing to **delay implementation of appropriate use criteria (AUC)** for advanced diagnostic imaging to no earlier than January 1, 2023, or the first January 1 that follows the end of the public health emergency if that is later than 2023.

The AUC program was initially approved as part of the Protecting Access to Medicare Act (PAMA) 2014 to require that referring providers billing Medicare through the Fee Schedule, the Hospital Outpatient Prospective Payment System, and Ambulatory Surgical Center payment systems use a clinical decision support mechanism to assess the appropriateness of the planned imaging. The program has been in an educational trial period since January 1, 2020. The AUC program will identify outlier ordering professionals who will be subject to prior authorization when ordering advanced imaging. The priority clinical areas to identify these outliers will be:

- Coronary artery disease (suspected or diagnosed)
- Suspected pulmonary embolism
- Headache (traumatic and non-traumatic)
- Hip pain
- Low back pain
- Shoulder pain (to include suspected rotator cuff injury)
- Cancer of the lung (primary or metastatic, suspected or diagnosed)
- Cervical or neck pain

Stark Law

CMS is proposing to **clarify one of the updates to the Physician Self-Referral (Stark) Law** as it relates

to the indirect compensation arrangement. Under this proposal, any unbroken chain of financial relationships where the compensation arrangement closest to the physician (or immediate family member of the physician) involves compensation for **anything** other than services they personally perform would be counted as an indirect compensation arrangement. For example, the rental of equipment or office space.

Electronic Prescribing of Controlled Substances

CMS is proposing to again **delay the compliance requirement for electronic prescribing of controlled substances (EPCS) for a covered Part D drug.** The new proposed compliance date is January 1, 2023. In advance of the 2023 implementation, CMS is stating that prescribers will only be considered compliant with the EPCS mandate if at least 70% of their Part D controlled substance prescriptions are prescribed electronically.

Quality Payment Program

Merit-Based Incentive Payment System (MIPS)

CMS is proposing the following performance category weights for Traditional MIPS participants reporting as individuals, groups, or virtual groups:

- Quality: 30% (decrease 10% from 2021)
- Cost: 30% (increase 10% from 2021)
- Promoting Interoperability: 25% (no change from 2021)
- Improvement Activities: 15% (no change from 2021)

The concept of a subgroup reporting option, which would allow multispecialty groups to self-identify groups of clinicians within their organization that intend to report the same measures, is being introduced. Beginning with 2023 Performance Year, CMS proposes allowing voluntary subgroup reporting for the MVP and APP.

MIPS Quality Performance Category Updates

CMS proposes the following updates to the quality performance category:

Maintain the data completeness criteria threshold of at least 70% for 2021 and 2022 MIPS performance periods (2023 and 2024 MIPS payment years) and increase the data completeness criteria threshold to at least 80% for the 2023 MIPS performance period (2025 MIPS payment year)."

The following measures previously finalized in the Orthopaedic Surgery Specialty Measure Set are being considered for removal:

- QID 021 - Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second Generation Cephalosporin
- QID 023 - Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
- QID 154 - Falls: Risk Assessment
- QID 317 - Preventive Care and Screening: Screening for High Blood Pressure and Follow-Up Documented

CMS plans to remove bonus points for end-to-end electronic reporting and reporting additional outcome/high priority beyond the 1 required.

MIPS Promoting Interoperability Category Updates

For the Provide Patients Electronic Access to their Health Information measure, **CMS is proposing a modification that would “require patient health information to remain available to the patient (or patient-authorized representative) to access indefinitely, starting with a date of service of January 1, 2016.”**

Final MIPS Scoring Updates

Due to the ongoing effects of COVID-19, **CMS plans to continue doubling the complex patient bonus for the 2021 MIPS performance year/2023 MIPS payment year.** MIPS participants can earn up to 10 bonus point to their final score.

CMS is proposing for the 2022 Performance Year that the performance threshold be set at 75 points. This is the minimum final score required to avoid a negative payment adjustment on CY 2024 Medicare Part B claims. The exceptional performers threshold is proposed for those scoring 89 points or more.

MIPS Value Pathways (MVPs)

Implementation of MIPS Value Pathways (MVPs) is being delayed again “to provide clinicians and third party intermediaries with sufficient time to prepare for a shift to this new participation framework”. **CMS is now proposing MVP implementation beginning January 1, 2023.**

Within the proposed rule, CMS lays out the timeline for MVP implementation. **It is important to note that CMS asserts its intent to eventually sunset the Traditional MIPS program and make MVP reporting mandatory.** It is considering mandatory MVP reporting beginning with the 2028 Performance Year.

The Agency has put forth an introductory set of 7 MVPs to be reportable starting with the 2023 Performance Year, **one of which is aimed at lower extremity joint repair.**

APM Performance Pathways (APP)

CMS has heard from stakeholders that the APP core quality measure set is not applicable to specialists, thus it is soliciting comments on reporting options for specialist providers within an ACO.

CMS also plan to make the CMS Web Interface available as a collection type for the 2022 performance period for MIPS Groups, Virtual groups, and Shared Savings Program ACOs reporting under the APP. CMS had previously planned to sunset the CMS Web Interface option beginning in 2022.

Advanced Payment Models

No significant changes are being proposed for Advanced Payment Models. QP and Partial QP thresholds remain unchanged from 2021 performance year. In 2023 they will likely increase.

Third Party Intermediaries

CMS is proposing a few changes to the third part intermediary general requirements:

- Must support MIPS reporting/submission for APM Entities. Third party intermediaries do not have to support submission of the Promoting Interoperability performance category for APM Entities.
- **“Beginning with the 2023 MIPS performance period/2025 MIPS payment year, QCDRs and qualified registries must support MVPs that are applicable to the MVP participants on whose behalf they submit MIPS data. QCDRs and qualified registries may also support the APP.”**
- CMS proposes that third party intermediaries must support subgroup reporting.

To learn more, read [AAOS' long-form summary of the proposed rule.](#)