# 2022 Medicare Physician Fee Schedule Proposed Rule

July 28, 2021

HEALTHCARE REGULATORY ROUND-UP

# 2022 Medicare Physician Fee Schedule Proposed Rule

## July 29, 2021

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PYA

# Agenda

1. Conversion factor reduction
2. List of covered telehealth services
3. New coverage for tele-behavioral health services
4. E/M changes
5. Billing for PA services
6. Appropriate use criteria
7. Medicare Diabetes Prevention Program
8. Remote therapeutic monitoring
9. Increased reimbursement for care management services
10. Quality Payment Program updates
11. MIPS Value Pathways
12. And a few other things….

# 1. Conversion Factor Reduction

- A bit of history –
  - 2019 to 2020: $.05 increase ($36.04 to $36.09) = 0.14% increase
  - 2020 to 2021 (final rule): $3.68 reduction ($36.09 to $32.31) = 10.2% reduction
  - 2020 to 2021 (CAA revision): $1.20 reduction ($36.09 to $34.89) = 3.33% reduction
- For CY2022 –
  - Proposed rate of $33.58: $1.31 reduction from current rate = 3.75% reduction
  - Impact of rate change varies by specialty
    - Impact ranges from loss of nearly 10% to gain of 15% or more

# 2. List of Telehealth Services

- Section 1834(m) –Medicare telehealth coverage
  - Geography
  - Location
  - Provider
  - Technology
  - Services
- Approved list of telehealth services
  - Permanent Category 1 and Category 2 services
  - 135 services added on temporary basis for duration of PHE

# Category 3 Services

| | |
|---|---|
| Services we are finalizing to remain temporarily on the Medicare telehealth list through the end of the year in which the PHE for COVID-19 ends (Category 3 services), to allow for continued development of evidence to demonstrate clinical benefit and facilitate post-PHE care transitions. | • Domiciliary, Rest Home, or Custodial Care services, Established patients (CPT 99336-99337)<br>• Home Visits, Established Patient (CPT 99349-99350)<br>• Emergency Department Visits, Levels 1-5 (CPT 99281-99285)*<br>• Nursing facilities discharge day management (CPT 99315-99316)<br>• Psychological and Neuropsychological Testing ( CPT 96130- 96133; CPT 96136- 96139)<br>• Therapy Services, Physical and Occupational Therapy, All levels (CPT 97161- 97168; CPT 97110, 97112, 97116, 97535, 97750, 97755, 97760, 97761, 92521- 92524, 92507)*<br>• and Hospital discharge day management (CPT 99238- 99239)*<br>• Inpatient Neonatal and Pediatric Critical Care, Subsequent (CPT 99469, 99472, 99476)*<br>• Continuing Neonatal Intensive Care Services (CPT 99478- 99480)*<br>• Critical Care Services (CPT 99291-99292)*<br>• End-Stage Renal Disease Monthly Capitation Payment codes (CPT 90952, 90953, 90956, 90959, and 90962)*<br>• Subsequent Observation and Observation Discharge Day Management (CPT 99217; CPT 99224- 99226)* |

- Proposing to extend coverage for these services through December 31, 2023 – opportunity to demonstrate qualification for Category 1 or 2

# Additional Category 3 Services?

- Radiation oncology
- Ophthalmological services
- Speech, language, and audiology services
- Cardiology services
- Ventilation Assistance Management
- Neurological Services
- Behavioral Health Services
- Physical, Occupational, and Speech Therapy
- Hospital Inpatient Services
- Observation Care Services
- Nursing Facility Services
- Home Services
- Office/Outpatient Services
- Critical Care Services
- Cardiac and Pulmonary Rehabilitation

# 3. Tele-Behavioral Health

- Consolidated Appropriations Act – eliminate geographic and location restrictions for diagnosis, evaluation, and treatment of mental health disorder
- Must have in-person, non-telehealth service by billing physician/practitioner within 6 months prior to initial telehealth service + each 6 months thereafter
  - Seeking comment on services furnished by practitioner in same group due to unavailability of regular practitioner
- May use audio-only communication technology (vs. audio/video required for other telehealth services)
  - But only if practitioner has audio/video capability but beneficiary lacks capacity or refuses to use video connection; new modifier
  - Seeking comment on other guardrails for audio-only visits (e.g., interval for in-person visits, add'l documentation of clinical appropriateness, limits on high-level services)

# 4. E/M Changes

## Split/Shared E/M Visits

- Defined as E/M visit provided in facility setting by physician and NPP in same group
- Billed by practitioner who provides >50% total time (who also must sign/date medical record)
- For new/established patients, initial/subsequent visits, prolonged visits, critical care services
- Identify both practitioners in medical record

## Critical Care Services

- May provide concurrently to same patient/same day by more than one practitioner representing more than one specialty
- No other E/M visit billed for same patient/same day when services furnished by same practitioner or practitioners in the same specialty and group
- Cannot be reported during same period as procedure with global surgical period

## Teaching Physician Services

- Time when teaching physician present can be included in determining E/M level
- For primary care exception, may only use MDM in determining E/M level

# 5. Billing for PA Services

- Currently, physician assistants cannot directly bill Medicare; services must be billed by PA's employer
- Consolidated Appropriations Act, 2021, amended relevant provision of Social Security Act to permit direct billing by PAs
  - No change to physician supervision requirement nor the payment percentage (85% of MPFS rate)
- CMS now proposes to amend regulations consistent with CAA provisions

# 6. Appropriate Use Criteria

- Created by Protecting Access to Medicare Act of 2014 (PAMA)
- Applies to advanced diagnostic imaging (ADI)
- Requires that the ordering professional consult a clinical decision support mechanism (CDSM) prior to ordering ADI
  - Service is appropriate, not appropriate, or not applicable
- CY2019 PFS final rule allows consultations by clinical staff under the direction of the ordering professional

# Appropriate Use Criteria

| | |
|---|---|
| Reporting required on hospital outpatient and professional claims (rendering) | CY2019 PFS final rule added IDTFs |
| Exceptions apply for emergencies, inpatient imaging services, and ordering professionals meeting MU hardship exception (lack of Internet access) | How to establish duration of emergency |
| Goal is to identify outlier ordering professionals | Could be subject to prior authorization |
| Effective January 2020; required January 2021 | Now **proposed delay** in penalty phase to the later of January 2023 or the January 1 that follows the declared end of the PHE |

# 7. Diabetes Prevention Program

- Despite millions being eligible for MDPP, less than 4,000 participating
- Propose eliminating Year 2 ongoing maintenance program requirements and payments and increasing Year 1 payments

| Payment Description | Current | Proposed |
|---|---|---|
| **Core Sessions (Months 1-6)** | | |
| Attend 1 Core Session or Bridge Payment | $26 | $26 |
| Attend 4 Core Sessions | $52 | $78 |
| Attend 9 Core Sessions | $95 | $130 |
| **Core Maintenance (CM) Sessions (Months 7-12)** | | |
| Attend 2 Core Maintenance Sessions (No 5% WL) in CM Interval 1 (Months 7-9) | $15 | $52 |
| Attend 2 Core Maintenance Sessions (5% WL) in CM Interval 1 (Months 7-9) | $63 | $106 |
| Attend 2 Core Maintenance Sessions (No 5% WL) in CM Interval 2 (Months 10-12) | $15 | $52 |
| Attend 2 Core Maintenance Sessions (5% WL) in CM Interval 2 (Months 10-12) | $63 | $106 |
| 5% WL Achieved from baseline weight | $169 | $189 |
| 9% WL Achieved from baseline weight | $26 | $26 |

# 8. Remote Therapeutic Monitoring

- Nothing new regarding remote *physiologic* monitoring; new reimbursement for monitoring non-physiologic (therapeutic) data
  - Respiratory and musculoskeletal system status, therapy (medication) adherence, therapy (medication) response
- New set of general medicine (not E/M) codes
  - CPT 989X1:  initial set-up and patient education
  - CPT 989X2:  data transmission – respiratory system
  - CPT 989X3:  data transmission – musculoskeletal system
  - CPT 989X4 and CPT 989X5 – RTM treatment management services

# Defining RTM

- Like RPM, RTM requires use of device that meets FDA definition of “medical device”
- Unlike RPM, RTM data can be self-reported by patient
- Unlike RPM, no reference to minimum of 16 days’ data
- AMA had intended to permit nurses and physical therapists to bill for RTM, but CMS disagrees
- Because RTM codes are not E/M codes, cannot be performed by clinical staff under general supervision
  - CMS seeking comment on potential resolution of this issue

# 9. Care Management

| Code | Descriptor | 2021 Payment | 2022 Proposed Payment | Difference |
|---|---|---|---|---|
| 99490 | CCM, clinical staff, initial 20 min | $41.17 | $63.47 | +$22.30 |
| 99439 | CCM, clinical staff, +20 min | $37.69 | $49.36 | +$11.67 |
| 99491 | CCM, physician/NPP, 30 min | $82.53 | $84.29 | $1.76 |
| **99X21** | CCM, physician/NPP, +30 min | n/a | $60.11 | n/a |
| 99487 | Complex CCM, clinical staff, 60 min | $91.77 | $138.35 | +$46.58 |
| 99489 | Complex CCM, clinical staff, +30 min | $43.97 | $71.86 | +$27.89 |
| 99X22 | PCM, physician/NPP, 30 min | $90.37 | $81.60 | -$8.77 |
| **99X23** | PCM, physician/NPP, +30 min | n/a | $59.44 | n/a |
| 99X24 | PCM, clinical staff, 30 min | $38.73 | $63.13 | +$24.40 |
| **99X25** | PCM, clinical staff, +30 min | n/a | $49.70 | n/a |

# 10. Quality Payment Program

- **2022 Performance Period Proposals**
  - Addition of clinical social workers and certified nurse mid-wives as eligible clinicians
  - Performance threshold of 75 points (up 15); additional performance of 89 points (final year of additional performance)
  - Category weights – Quality & Cost (30% each), PI (25%), Improvement Activities (15%)
  - Quality –
    - Eliminating bonus points for end to end reporting and high priority measures as well as 3-point floor*
    - Provide alternate benchmarks for 2022 PY
    - Continue CMS Web Interface for 2022 PY
    - Update measures (195 measures for 2022 PY)
    - Increase data completeness requirement to 80% for 2023 PY

# 10. Quality Payment Program

- **2022 Performance Period Proposals**
  - Cost – adding 5 new episode-based cost measures
  - Improvement Activity – adding 7 new activities (promoting health equity), modifying 15 (11 address health equity) and removing 6.
  - Promoting Interoperability –
    - Automatic reweighting for clinical social workers and small practices
    - Revise reporting requirements
      - Requirement that patients can access their health information indefinitely for encounters after 1/1/16
      - Require attestation of annual completion of High-Priority Guide on the Safety Assurance Factors for HER Resilience Guides (SAFER Guides)
      - Modify Information Blocking attestations to differentiate from ONC requirements in 21st Century Cures Act

# 10. Quality Payment Program

- **2022 Performance Period Proposals**
  - Continuing complex patient bonus – capped at 10 points added to the final score
  - Facility based groups – quality and cost score will be based on facility-based measurement of scoring unless a clinician receives a higher MIPS final score through another submission
  - Reweighting updates for small practices
    - If PI is re-weighted to 0, quality = 40%, cost = 30% and IA = 30%
    - If PI and cost are re-weighted to 0, quality = 50% and IA = 50%
  - Care Compare to include affiliations with LTC, IRF, IP Psych, SNF, HHA, Hospice and ESRD facilities

# 11. MIPS Value Pathways

- Goal – meaningful comparison among like specialties, medical conditions or episode of care while reducing reporting burden and improving patient care
- Registration process between April 1 and November 30
  - Voluntary option to traditional MIPS… for the time being
- Timeline
  - PY 2023 and 2024 for individual clinicians, single/multispecialty groups, subgroups and APM entities on an MVP for all MIPS categories
  - PY 2025 – multispecialty groups required to form subgroups
  - PY 2023 – 2027 – add specialties to MVP list
  - ?? Sunset traditional MIPS by PY 2027
- Requires QCDRs, QRs, and Health IT vendors support MVPs relevant to the specialties they support by 2023 PY

# MIPS Value Pathways

- Proposed MVPs
  - Rheumatology
  - Stroke Care and Prevention
  - Heart Disease
  - Chronic Disease Management
  - Emergency Medicine
  - Lower Extremity Joint Repair
  - Anesthesia
- Each includes complementary measures and activities with emphasis on outcomes, population health, health equity, interoperability and reduced reporting burden for clinicians
- Scoring, re-weighting will align with traditional MIPS with a few exceptions

# MIPS Value Pathways

## Appendix A: MVP Reporting Requirements

The table below provides an overview of the MVP reporting requirements.

| Quality Performance Category* | Improvement Activities Performance Category* | Cost Performance Category |
|---|---|---|
| An MVP Participant selects 4 quality measures, 1 must be an outcome measure (or a high priority measure if an outcome is not available or applicable).<br><br>**Note:** As applicable, an administrative claims measure, that is outcome-based, may be selected at the time of MVP registration to meet the outcome measure requirement. | MVP Participant selects:<br>Two medium weighted improvement activities<br>**OR**<br>One high weighted improvement activity.<br>**OR**<br>Participates in a certified or recognized patient-centered medical home (PCMH) or comparable specialty practice, as described at (82 FR 53652) and at §414.1380(b)(3)(ii) | An MVP Participant is scored on the cost measures included in the MVP they select and report. |
| **Foundational Layer (MVP Agnostic)** | | |
| **Population Health Measures***<br>An MVP Participant selects 1 population health measure, at the time of MVP registration, to be scored on. The results are added to the quality performance category score.<br><br>**Promoting Interoperability (PI) Performance Category**<br>An MVP Participant is required to meet the Promoting Interoperability performance category requirements at § 414.1375(b). | | |

*Indicates MVP Participant may select measures and/or improvement activities.

# 12. And a Few Other Things

- Therapy Services
  - Services furnished by PTAs and OTAs
- Outpatient Pulmonary Rehabilitation
  - Expanded coverage for those hospitalized with COVID-19 and experience persistent symptoms
- Open Payments
  - Clarifications regarding delaying general payments, reporting of research payments, and reporting of ownership records
  - New required field for teaching hospital records
- Medicare Shared Savings Program
  - New methodology for calculating repayment mechanism amounts

# Submitting Comments

- CMS statutorily required to consider/respond to comments in preparing the Final Rule
- Subject matter
  - Specific proposal
  - CMS request for comment (e.g., direct supervision through use of real-time audio-visual connection
- Mechanics
  - Due September 13, 2021
  - Submit electronically through Regulations.gov (CMS-1751-P)
  - May submit anonymously
- Expect 2022 MPFS Final Rule to be published on/about December 1, 2021

# Join Us August 11th!

- 2022 Hospital OPPS and ASC Payment System Proposed Rule

1. OPPS and ASC payment rate updates
2. Reversal of 2021 changes to the Inpatient Only list
3. Reversal of 2021 changes to the ASC Covered Procedure list
4. Increase in penalties for price transparency rules
5. Clarification of rules regarding online price estimator tools
6. 340B program payment rates
7. Radiation Oncology Model timing and design
8. Payment for non-opioid pain management drugs and biologicals
9. Comment solicitation – post-pandemic continuation of public health emergency flexibilities
10. Request for Information – Rural Emergency Hospital Program

# Questions?

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