ADVOCATE
REVENUE CYCLE MANAGEMENT

CMS Finalizes Rules for 2022 Medicare Physician Fee Schedule

On November 2nd, the Centers for Medicare & Medicaid Services (CMS) issued the final policy updates for the Medicare physician fee schedule payments and policies for 2022 – available HERE. In this ruling, CMS is finalizing their proposals related to payment policies, the Quality Payment Program (QPP), and again delaying the implementation of the Appropriate Use Criteria/Clinical Decision Support program to 2023 or later.

Conversion Factor

The 2022 Conversion Factor accounts for the expiration of the CAA, as well as the annual required budget neutrality adjustments (which CMS has calculated at -.14%). The passage of the Consolidated Appropriations Act of 2021 (CAA) provided a +3.75% increase in the conversion factor which offset the cuts related to adopting evaluation and management coding changes as finalized by CMS.

The resulting decrease to the conversion factor and estimated impact for a selection of specialties is included below:

- **Final Medicare Fee Schedule CF: $33.58**
  - Decrease of -$1.30 from 2021 CF of $34.89
- **Final Anesthesia CF: $20.93**
  - Decrease of -$.63 from 2021 CF of $21.56

Specialty*	Work RVU	Practice Expense RVU	Malpractice Expense RVU	Proposed Combined Impact	Final Combined Impact**
Anesthesiology	0%	1%	0%	1%	1%
Nurse Anes / Anes Asst	0%	1%	0%	1%	0%
Dermatology	0%	1%	0%	1%	1%
Radiology	0%	-1%	0%	-2%	-1%
Radiation Oncology/Radiation Therapy	0%	-1%	0%	-5%	-1%
Interventional Radiology	0%	-5%	0%	-9%	-5%
Nuclear Medicine	0%	-1%	0%	-1%	-1%
Pathology	0%	0%	0%	-1%	0%

**Full specialty impact table is available within the final rule. Be aware that different billing arrangements will influence the final outcomes of CMS's estimated impacts.*

***Final combined impact estimates are **averages** of allowable charges by specialty. Real-world impact depends heavily on case-mix and location. For example, Interventional Radiology services performed in a hospital will have less of an impact than Interventional Radiology services performed in an office/non-facility due to the difference in PE RVUs between Facility and Non-Facility Settings.*

Why is this happening?

The most widespread impacts of RVU changes are related to updates resulting from CMS's misvalued code initiative. Other adjustments stem from annual American Medical Association (AMA) RUC (Relative-value unit Update Committee) recommendations and updates to clinical labor pricing, which both impact the Practice Expense relative value unit.

Based on stakeholder feedback, CMS has opted to perform a 4- year phase in for the updates related to clinical labor pricing citing the fact that certain specialties have higher supply/equipment costs resulting in a disproportionate impact. As a result, Interventional Radiology and Radiation Oncology will be less impacted by RVU updates than originally expected by the proposed rule.

Further Medicare Cuts Possible for 2022

Independent of the changes to the Conversion Factor beginning in 2022, all providers may experience additional decreases to Medicare reimbursement due to sequestration cuts currently scheduled to go into effect January 1st, 2022.

- -2% Medicare Sequester - Since 2013, Medicare has been subject to an automatic annual "sequestration" cut of 2% as required by the Budget Control Act of 2011. During the pandemic, Congress implemented a temporary reprieve from these cuts and extended this moratorium through the end of 2021.
- -4% "PAYGO" Sequester – The passage of the American Rescue Plan Act triggered a statutory Pay-As-You-Go (PAYGO) budget control measure that offsets an increase to the federal deficit by automatically reducing federal spending.

Both sequester cuts require Congressional intervention to avoid being implemented at the start of the year.

Appropriate Use Criteria/Clinical Decision Support (AUC/CDS)

CMS has finalized a delay of the penalty phase of the AUC/CDS program to January 1st, 2023, or the first year following the end of the COVID-19 public health emergency, whichever is the latter.

CMS cites implementation challenges, lack of industry readiness, and the continued impact of the pandemic as reasons to delay the penalty phase of the program, intended to begin January 1st, 2022.

The AUC program, currently in the 'operations and testing phase', requires ordering physicians to consult appropriate use criteria when ordering advanced imaging studies for Medicare beneficiaries. Radiologists are required to report AUC related modifiers on relevant claims, provided by the ordering physician, for claims to be reimbursed during the eventual penalty phase of the program.

CMS notes that, based on claims data from the 2020 year of the testing period, approximately 10% of claims were considered AUC compliant to be reimbursed under the mandate. In other words, 90% of applicable claims would have been denied if 2020 had not been a testing year.

Critical Access Hospitals and AUC

Due to rules related to applicable payment systems of the AUC mandate, Critical Access Hospitals (CAH) are exempt from the consultation and reporting requirements. CMS approached the issue of claims processing for CAH under the mandate within the proposed rule, suggesting to recycling the use of the MH modifier to identify CAH.

CMS has decided against this proposal and will, instead, retire the MH modifier with the start of the penalty phase of the program. Instead, a new modifier will be created to signify claims where the AUC mandate does not apply, and CMS will explore identifying CAH locations based on the CMS Certification Number (CCN).

Scope of Practice

CMS will allow Physician Assistants to bill Medicare directly for professional services starting January 1st, 2022. The finalization of this proposal implements sections of the CAA which authorize Medicare to make direct payment to PAs for professional services under Medicare Part B. Currently, Medicare can only make payment to the employer or independent contractor of a PA.

Evaluation and Management (E/M) Coding

As a result of the general restructuring of Evaluation and Management codes, CMS has refreshed their guidelines for shared or split billing for E/M visits. CMS has finalized the following provisions:

- Finalizing the 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 practitioner who provides the substantive portion of the visit.
- The practitioner who provides the **substantive portion** of the visit (more than half of the total time spent) would bill for the visit.
    - Defining what the 'substantive portion' of the visit means for 2022 and 2023:
        - **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).
        - **2023** - the substantive portion of the visit will be defined as more than half of the total time spent.
- Documentation in the medical record would be needed to identify the two individuals who performed the visit. The individual providing the substantive portion must sign and date the medical record.
- Split (or shared) visits could be reported for new as well as established patients, and initial and subsequent visits, as well as prolonged services.
- Split (or shared) visits would be reported via a modifier on the claim for program integrity. CMS did not define the specific modifier within the final rule.

Removal of Select National Coverage Determinations

CMS has removed the national coverage determination (NCD) for position emission tomography (PET) scans (NCD 220.6). Removing the NCD would defer coverage decisions to local Medicare Administrative Contractors (MACs). The existing NCD for PET was last updated in 2013 and requires separate NCDs for every non-oncologic indication for PET scans. CMS believes that

allowing local contractors the discretion to consider coverage would allow Medicare beneficiaries greater access to PET scans for non-oncologic indications.

Quality Payment Program (QPP/MIPS)

CMS continues to advance the Quality Payment Program (QPP) forward with many proposals related to the Merit-Based Incentive Program (MIPS) and the transition to MIPS value pathways.

CLICK HERE for a summary of final provisions for the 2022 performance year.

As always, ADVOCATE will keep you up to date on this and all issues impacting medical groups as they become available.

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