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Part B News
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Special Issue

Coverage of the final 2022 Medicare physician fee schedule and Quality Payment Program

In this issue

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Billing

CMS widens scope of split/shared policy, firms up billing rules

Prepare for major changes to the way your practice bills original split/shared services — traditionally performed in the hospital setting — that will go into effect Jan. 1, 2022. CMS will implement the new guidelines it released in the proposed 2022 Medicare physician fee schedule, but it added a transitional plan designed to smooth the switch to the new billing policy (*PBN 7/26/21*).

Consider five main points in the new guidelines, which CMS confirmed in the final 2022 Medicare physician fee schedule released Nov. 2:

1. The treating provider who performs the "substantive portion" of the visit will bill the service.
2. Split/shared facility services may be billed for encounters in any facility setting, including the emergency department and skilled nursing facilities.
3. The service may be billed for initial and subsequent encounters, for new and established patients and for critical care services (**99291-99292**).
4. Prolonged services are allowed for codes that have a typical time in the descriptor.
5. The services must be reported with a new modifier — **FS** (Split [or shared] evaluation and management visit). CMS released the modifier in the latest quarterly HCPCS code update published Nov. 8.

Practices should focus on how to calculate the "substantive portion" of the visit because it is a unique approach to billing that will determine which practitioner bills the service and how much revenue the practice receives.

Get ready for 2022 E/M updates

CMS is unleashing big changes to E/M coding, billing and documentation policy starting Jan. 1, 2022. From revisions for split/shared billing policy to a wide-ranging update on critical care services, a flurry of new policies will hit medical practices in the new year. Prepare for the updates during the Nov. 23 webinar **E/M for 2022: Brace for Revised Medicare Policies, Code Updates**. Learn more: *https://codingbooks.com/ympda112321*.

Calculating 'substantive portion'

In 2022, you can calculate the substantive portion of the visit based on time or performance of a key component.

To calculate based on time, both practitioners will need to document the time they spent on the nine activities that are used for time-based coding of office and other outpatient visits (**99202**-**99215**) on the date of the encounter.

The encounter should be billed under the name and national provider identifier (NPI) of the person who spends the greatest amount of time — i.e., more than 50% — on the activities. Practices should not use the counseling/coordination of care rules to calculate time for billing facility split/shared services.

Time-based billing was the original proposal, but in response to negative comments about the plan CMS created a key component option: The practitioner who performs a key component of a visit — history, exam or medical decision-making — will bill the service. But note that the key component option is only available in 2022 (*see chart, p. 3*).

"We also are clarifying that when one of the three key components is used as the substantive portion in 2022, the practitioner who bills the visit must perform that component in its entirety in order to bill," CMS says in the final rule.

The billing provider must fully document what's required for that element, says Betsy Nicoletti, CPC, president of Medical Practice Consulting in North Andover, Mass.

Time-based billing could free physician time

Even though CMS created the key component option in response to complaints about time-based billing, two statements in the final rule may make a focus on time more attractive:

- **A face-to-face encounter is not required**. The billing practitioner doesn't have to see the patient. "The substantive portion could be entirely with or without direct patient contact and will be determined by the proportion of total time, not whether the time involves direct or in-person patient contact," CMS said in response to several comments. That means that if a physician spends 20 minutes on activities that do not need to be performed face-to-face, such as ordering procedures, interpreting test results, conferring with other physicians or coordinating care, and the NPP spends 15 minutes with the patient getting a history, performing a physical exam and counseling the patient, the physician will bill the service.
- **Timekeeping is an individual choice**. CMS also received questions about how it wanted practices to track time. "We believe we should leave it to the discretion of individual practitioners and the groups they work in to decide how time will be tracked," the final rule states.

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Definition of 'substantive portion' for E/M visit code families		
E/M visit code family	**2022 definition of substantive portion**	**2023 definition of substantive portion**
Other outpatient*	History or exam or MDM or more than half of total time	More than half of total time
Inpatient, observation, hospital, nursing facility	History or exam or MDM or more than half of total time	More than half of total time
Emergency department	History or exam or MDM or more than half of total time	More than half of total time
Critical care	More than half of total time	More than half of total time

*According to CMS, "office visit will not be billable as split (or shared) visits
Source: Table 26, final 2022 Medicare physician fee schedule

Be careful with two challenging areas

Component-based billing will be available for one year to help practices transition to the time-based model that will be the only option in 2023. Even though the dual option gives practices greater choice, you should weigh the effort of training staff on the component-based option against the length of time they'll be able to use it, notes David Glaser, shareholder, Fredrikson & Byron's Health Law Group, Minneapolis.

"Anytime there is more flexibility, it is easier in one sense. The problem, of course, is complexity," Glaser says. "There is an interesting question as to how to approach education when you know a policy has a 12-month life. Should you teach the whole thing or stick to what the policy will be in 12 months to keep things simpler? That question will challenge compliance professionals for the next year."

The final rule contains another challenge, Nicoletti says. In a chart that outlines the billing options for various E/M services in 2022, key component billing is an option for other outpatient services (99202-99215), but history and exam are not key components of those codes, Nicoletti points out. "It makes no sense," she says.

Stay tuned to *Part B News* as it covers additional guidance from CMS in the coming weeks. — *Julia Kyles, CPC* (*jkyles@decisionhealth.com*) ■

Physician payments

Clinical labor pricing gets reboot ahead of 4-year phase in period

CMS is launching a four-year initiative to fix flaws in its clinical labor pricing data. For the first time in two decades, the agency will update its non-physician labor inputs to bring them in line with current market and staffing trends.

Over a four-year period beginning in 2022, CMS will gradually phase in the revised clinical labor pricing updates across dozens of non-physician labor groups, such as registered nurses and technicians (*see chart, p. 7, for revised clinical labor inputs*).

Payments for individual services made under the fee schedule reflect physician work, professional liability insurance and practice expense (PE) components. Clinical labor pricing is one of the pieces that feeds into the larger PE component that CMS uses to determine payments for many service-level code valuations.

CMS is using updated Bureau of Labor Statistics wage data to ascertain current labor pricing in today's economic environment. "Continuing to use clinical labor cost data that are nearly two decades old would create distortions in relativity that undervalue many services which involve a higher proportion of clinical labor," CMS stated in the final rule.

The revised data will bring a significant boost to many clinical groups. **Example**: Radiation therapists will see a +78% increase to clinical labor pricing between 2022 and 2025, the final year of the phase in. Over that period, the current rate per minute for radiation therapists will increase from $0.50 to $0.89.

About three dozen labor groups, from lab technicians and physical therapy assistants to registered nurses and audiologists, are on track for labor pricing updates of +40% or more during the phase-in period.

The impact of the pricing update is likely to have a downstream effect on medical practices, notes Sterling N. Ransone Jr., M.D., FAAFP, president of the American Academy of Family Physicians (AAFP) in Leawood, Kan.

"Over the past two decades, annual wages for medical assistants has increased 30% and wages for registered nurses has increased more than 60%," Ransone says. "Updating clinical labor pricing is critical to ensure that physician practices can afford to recruit and retain clinical staff."

When fully updated in 2026, the labor pricing changes are expected to increase total Medicare payments to the family practice specialty by +2%. Endocrinology also will see a +2% gain, and numerous other specialties, including nurse practitioner, internal medicine and physician assistant, are on track to gain a +1% boost. Others, such as hematology/oncology (-2%) and vascular surgery (-5%), would take payment losses.

"Specialties with a substantially lower or higher than average share of direct costs attributable to labor would experience significant declines or increases, respectively," CMS states in the final rule.

The update comes at an important time for medical groups, according to Ransone. "The agency has been relying on outdated data from 2002," he says. "The COVID-19 pandemic has exacerbated clinical staffing shortages, making it more urgent than ever to ensure that CMS is appropriately paying for labor costs, which are a major part of practice expenses in primary care."

To access the final labor fees, see "Table 12: Finalized Clinical Labor Pricing Update" in the final rule. To see the specialty impact of the labor pricing updates, consult "Table 13: Anticipated Final Clinical Labor Pricing Effect on Specialty Impacts." — *Richard Scott* (*rscott@decisionhealth.com*) ■

Telehealth

COVID-era telehealth to remain through 2023. After that, the future is unclear.

CMS finalized the extension of "Category 3" COVID telehealth codes through 2023 at least but did not execute bigger changes that would make many of them permanent.

Originating site rules that limit who can charge for telehealth services were temporarily suspended for certain codes under emergency rulemaking in March 2020, and CMS has been adding codes to the list ever since (*PBN 3/23/20*, *4/19/21*). The agency added Category 3 codes — distinct from the usual Category 1 and Category 2 codes for Medicare telehealth services established in 2003 — to payable telehealth services "on a temporary basis" for the COVID-19 public health emergency (PHE) in the final 2021 physician fee schedule (*PBN blog 12/2/20*).

These codes were to be removed in 2022 or at the end of the PHE, but now will be kept through 2023 at a minimum, CMS says. The agency also says it will allow more comments from stakeholders before a final decision on the codes.

Telehealth outpatient cardiac rehabilitation codes **93797** and **93798**, and the related HCPCS codes **G0422** and **G0423**, are now included among the Category 3 codes, according to provisions in the final 2022 Medicare physician fee schedule. CMS also added virtual check-in code **G2252** (Brief communication technology-based service, e.g., virtual check-in service) through a direct crosswalk to CPT code **99442** on a permanent basis.

Mental health expands permanently

You can remove the site-based barriers when furnishing mental health services to patients in the home.

The agency approved its earlier proposal to eliminate geographic barriers and allow patients in their homes to access telehealth services for the diagnosis, evaluation and treatment of mental health disorders.

CMS also is finalizing authorization of audio-only telehealth services for mental health disorders for certain established patients in their homes if the provider dispensing the services can furnish two-way audio/video communications but the beneficiary is unwilling or incapable of using it. Note: CMS announced a new modifier for this — **FQ** (The service was furnished using audio-only communication technology) — in the latest quarterly HCPCS code update published Nov. 8.

The rule also allows rural health clinics and federally qualified health centers to perform audio-only virtual mental health. Such calls already allowed for substance use disorder (SUD) treatment.

Waiting for laws

Commenters on the proposed rule had been vocal about wanting the categories of telehealth codes extended, and industry reactions to the telehealth features of the rule have been positive on balance (*PBN 9/27/21*). The American College of Physicians (ACP) was satisfied with the audio-only mental health flexibilities, but "disappointed that E/M services were not included." Maintenance of the Category 3 code flexibilities will be a relief to many providers whose homebound or risk-averse patients enjoy the flexibility of the COVID telehealth standards.

But throughout the rule CMS makes clear that when the PHE is over, all bets are off, and it isn't going to be too adventuresome about asserting its own authority as opposed to direct permission from Congress to permanently change telehealth rules.

In explaining its decisions on many codes that stakeholders had asked to add or make permanent to the telehealth coverage categories, CMS frequently cited its lack of authority. For therapy telehealth codes, for example, the agency wrote, "physical therapists (PTs), occupational therapists (OTs), and speech-language pathologists (SLPs) are not among the

(*continued on p. 6*)

Benchmark of the week

CY2022 specialty impact: Final fee schedule winners and losers

While the 4% cut to the 2022 conversion factor is coming for all specialties, the impact of relative value unit (RVU) changes harbors its own outlook – fluctuating from a 6% gain for diagnostic testing facility to a -5% drop for interventional radiology and vascular surgery.

Of the 55 specialties that CMS covers, 31 of them are on track for a flat year-to-year RVU impact. Specialties from emergency medicine, gastroenterology and internal medicine will see a 0% change to combined RVU impact in 2022, according to "Table 136: CY 2022 PFS Estimated Impact on Total Allowed Charges by Specialty" contained in the final 2022 Medicare physician fee schedule, which CMS released Nov. 2.

Yet a dozen specialties will see an increase in RVU impact in 2022. After diagnostic testing facility comes portable X-ray supplier (+2%), followed by 10 other specialties with a +1% year-to-year change. On the reverse side, 12 specialties will face combined RVU cuts in the new year, although after the top two specialties in the red, the rest sit at -1%.

Overall, the final fee schedule has dampened the impact of RVU changes compared to the proposals in July. At that point, 20 specialties were on track for RVU gains, with 18 projected to be in the red. – *Richard Scott* (rscott@decisionhealth.com)

Top 12 specialty winners, impact on total allowed charges, CY 2022

Specialty	Allowed charges (mil)	Impact of work RVU changes	Impact of PE RVU changes	Impact of MP RVU changes	Combined impact
Diagnostic testing facility	$664	0%	6%	0%	6%
Portable X-ray supplier	$83	0%	2%	0%	2%
Anesthesiology	$1,626	0%	1%	0%	1%
Dermatology	$3,336	0%	0%	0%	1%
Family practice	$5,557	0%	0%	0%	1%
General practice	$361	0%	0%	0%	1%
Geriatrics	$170	0%	1%	0%	1%
Hand surgery	$214	0%	1%	0%	1%
Interventional pain management	$865	0%	2%	0%	1%
Plastic surgery	$311	0%	0%	0%	1%
Podiatry	$1,797	0%	1%	0%	1%
Urology	$1,623	0%	0%	0%	1%

Top 12 specialty losers, impact on total allowed charges, CY 2022

Specialty	Allowed charges (mil)	Impact of work RVU changes	Impact of PE RVU changes	Impact of MP RVU changes	Combined impact
Interventional radiology	$465	0%	-5%	0%	-5%
Vascular surgery	$1,107	0%	-5%	0%	-5%
Cardiology	$5,926	0%	-1%	0%	-1%
Hematology/Oncology	$1,679	0%	-1%	0%	-1%
Nuclear medicine	$48	0%	-1%	0%	-1%
Oral/Maxillofacial surgery	$70	0%	-1%	0%	-1%
Physical/Occupational therapy	$3,850	0%	-1%	0%	-1%
Radiation oncology and radiation therapy centers	$1,605	0%	-1%	0%	-1%
Radiology	$4,257	0%	-1%	0%	-1%
Audiologist	$58	0%	-1%	0%	-1%
Rheumatology	$523	0%	0%	0%	-1%
Thoracic surgery	$293	0%	-1%	0%	-1%

Source: *Table 136, final 2022 Medicare physician fee schedule*

(*continued from p. 4*)

practitioners identified in section 1842(b)(18)(C) of the Act [who can dispense telehealth]."

Lawmakers have introduced numerous bills aimed at expanding telehealth flexibilities in recent months. One such bill, the Expanded Telehealth Access Act, was introduced in the U.S. House of Representatives in March. That bill would "permanently allows audiologists, physical therapists, occupational therapists, speech-language pathologists and other providers designated by [CMS] to provide telehealth services under Medicare." But the bill, like other similar ones, appears stuck.

Supervision stalls

CMS also declined to rule on making its direct supervision telehealth allowance permanent (*PBN 7/26/21*). The agency cited MedPAC, which had sent a cautionary letter to CMS on Sept. 9, 2021, warning that "allowing clinicians to supervise 'incident to' services virtually could pose a safety risk to beneficiaries because the clinician would not be physically available to help the individual being supervised, if necessary, which is important if the service is a complex procedure." CMS also cited spending issues.

Rebecca E. Gwilt, Esq., co-founder and partner at Nixon Gwilt Law in Richmond, Va., hopes that CMS will find a way to interpret its authority more broadly when the PHE ends. With regard to supervision, for example, "CMS could choose to exercise its interpretive powers using subregulatory guidance to enable a provider to meet 'direct supervision' requirements through 'virtual presence' — that is, live, interactive audio/video or even audio-only telehealth. This change in policy could mean a great deal to [therapy] practitioners whose only option for Medicare reimbursement is to bill 'incident to' once the PHE ends." — *Roy Edroso (redroso@decisionhealth.com)* ■

Quality Payment Program

Tough year, big change: MIPS players challenged on scores, then by MVP

The delay on a full switchover to the MIPS Value Pathways (MVP) program may relieve anxious participants, but experts say it's merely a reprieve in a Quality Payment Program (QPP) that is slated to undergo fundamental change in coming years. In 2022, in what may be the final year of traditional MIPS reporting, providers will face thresholds that are higher than ever, and participants who've been breezing through may find rougher going.

Originally scheduled to begin in 2021, then in 2022, MVP — a major rethinking of reporting requirements for the program — will start for MIPS participants with the 2023 performance/2025 reporting year, according to the final 2022 Medicare physician fee schedule (*PBN 7/26/21*).

Under MVP, MIPS performance will be reported in new categories that will be relevant to specific specialties, medical conditions or episodes of care. An MVP subgroup is defined as "a subset of a group which contains at least one MIPS-eligible clinician and is identified by a combination of the group TIN, the subgroup identifier and each eligible clinician's NPI," according to CMS.

At first glance, MVP looks like a reduction in provider effort: As described in new CMS materials, MVP reporters who currently report at least six Quality measures will report four Quality measures, one of which must be an outcome measure. They will report two medium-weighted or one high-weighted Improvement Activity (or, for some reporters, membership in a patient-centered medical home), rather than four medium- or two high-weighted activities currently, and the same seven required Promoting Interoperability measures (e.g., security risk analysis, e-prescribing) as now. Cost will still be calculated by CMS.

But you'll find significant changes to the standards for reporting: Participants will be slotted into condition-specific pathways that will dictate the measures they report. They also will be assigned population health measures.

CMS promises to phase in some requirements over time: For example, multispecialty groups, which will be required to form subgroups for the MVP reporting process and would have started that in 2025 under the proposed rule, will now start in the 2026 performance/2028 reporting year. More details will be forthcoming in the 2023 rules.

Last leg's the hardest

But in 2022, simply breaking even in MIPS will be tough. Category weights are finalized for 2022 at 30% for the Quality performance category (down 10% from 2021); 30% for the Cost performance category (up 10% from 2021); 15% for the Improvement Activities performance category; and 25% for the Promoting Interoperability performance category. The performance threshold leaps from 60% to 75%, and the data completeness criteria threshold will be 70% (the proposed rule had the latter amount at 80%).

CY2022 Final Clinical Labor Pricing Update

Labor code	Labor description	Current rate per minute	Updated rate per minute	2022 rate per minute (Year one)	Total % change
L023A	Physical therapy aide	0.23	0.28	0.24	22%
L026A	Medical/technical assistant	0.26	0.36	0.29	38%
L030A	Lab tech/MTA	0.30	0.46	0.34	53%
L032B	EEG technician	0.32	0.44	0.35	38%
L033A	Lab technician	0.33	0.55	0.39	67%
L033B	Optician/COMT	0.33	0.39	0.35	18%
L035A	Lab tech/Histotechnologist	0.35	0.55	0.40	57%
L037A	Electrodiagnostic technologist	0.37	0.44	0.39	19%
L037B	Histotechnologist	0.37	0.55	0.42	49%
L037C	Orthoptist	0.37	0.76	0.47	105%
L037D	RN/LPN/MTA	0.37	0.54	0.41	46%
L037E	Child life specialist	0.37	0.49	0.40	32%
L038A	COMT/COT/RN/CST	0.38	0.52	0.42	37%
L038B	Cardiovascular technician	0.38	0.60	0.44	58%
L038C	Medical photographer	0.38	0.38	0.38	0%
L039A	Certified retinal angiographer	0.39	0.52	0.42	33%
L039B	Physical therapy assistant	0.39	0.61	0.45	56%
L039C	Psychometrist	0.39	0.64	0.46	62%
L041A	Angio technician	0.41	0.58	0.45	41%
L041B	Radiologic technologist	0.41	0.63	0.47	54%
L041C	Second radiologic technologist for vertebroplasty	0.41	0.63	0.47	54%
L042A	RN/LPN	0.42	0.63	0.47	50%
L042B	Respiratory therapist	0.42	0.64	0.48	52%
L043A	Mammography technologist	0.43	0.63	0.48	47%
L045A	Cytotechnologist	0.45	0.76	0.53	69%
L045B	Electron microscopy technologist	0.45	0.89	0.56	98%
L045C	CORF social worker/psychologist	0.45	0.70	0.51	56%
L046A	CT technologist	0.46	0.76	0.54	65%
L047A	MRI technologist	0.47	0.76	0.54	62%
L047B	REEGT (Electroencephalographic tech)	0.47	0.76	0.54	62%
L047C	RN/Respiratory therapist	0.47	0.70	0.53	49%
L047D	RN/Registered dietician	0.47	0.70	0.53	49%
L049A	Nuclear medicine technologist	0.62	0.81	0.66	32%
L050A	Cardiac sonographer	0.50	0.77	0.57	54%
L050B	Diagnostic medical sonographer	0.50	0.77	0.57	54%
L050C	Radiation therapist	0.50	0.89	0.60	78%
L050D	Second radiation therapist of IMRT	0.50	0.89	0.60	78%
L051A	RN	0.51	0.76	0.57	49%
L051B	RN/Diagnostic medical sonographer	0.51	0.77	0.58	51%
L051C	RN/CORF	0.51	0.76	0.57	49%
L052A	Audiologist	0.52	0.81	0.59	56%
L053A	RN/Speech pathologist	0.53	0.79	0.60	49%
L054A	Vascular technologist	0.54	0.91	0.63	69%
L055A	Speech pathologist	0.55	0.82	0.62	49%
L056A	RN/OCN	0.79	0.81	0.80	3%
L057A	Genetics counselor	0.57	0.85	0.64	50%
L057B	Behavioral health care manager	0.57	0.57	0.57	0%
L063A	Medical dosimetrist	0.63	0.91	0.70	44%
L107A	Medical dosimetrist/Medical physicist	1.08	1.52	1.19	41%
L152A	Medical physicist	1.52	2.14	1.68	41%

Source: Table 12, Finalized Clinical Labor Pricing Update, final 2022 Medicare physician fee schedule

The exceptional performance threshold that makes high performers eligible for a special bonus, in its last year of existence, will be 89 points. That may benefit the few who can attain it; in years past the available bonus came to very little when it was split among everyone who qualified (*PBN 2/4/19*).

New Cost measures

CMS is adding five episode-based MIPS measures to the Cost category metrics by which they calculate the MIPS participant's score:

- Melanoma Resection.
- Colon and Rectal Resection.
- Sepsis.
- Diabetes.
- Asthma/Chronic Obstructive Pulmonary Disease (COPD).

The current Cost measures are Total Per-Capita Costs (TPCC), Medicare Spending per Beneficiary Clinician (MSPB Clinician) and 18 other episode-based measures. CMS also is working on a process whereby all Cost measures would be "developed by CMS' measure development contractor."

For APM entities — that is, APMs that either choose not to be scored in the Advanced APMs QPP track or do not qualify for lack of qualified participants (QPs) or other reasons — the metrics in 2022 are the same as 2021: Quality is 55%; Cost is 0%; Promoting Interoperability is 30%; and Improvement Activities is 15%.

For APMs that are on the Advanced APM track, the APM Incentive Payment remains 5% of Part B covered professional services and will be paid to the qualifying participant's (QP) TIN or divided proportionally between or among the TINs with which the QP is associated, based on the relative paid amount for Part B covered professional services that are billed through each of the TINs.

Clinical social workers and certified nurse midwives are added to MIPS-eligible providers.

Doubling down on MVP

Dave Halpert, chief, client team of Roji Health Intelligence in Chicago, says that in the final rule "CMS doubles down on its commitment to move providers out of 'traditional MIPS' and into APMs [alternative payment models] or MVPs."

With ACOs in the Shared Savings plan, for example, Halpert sees CMS attempting to lure MIPS participants by "delaying the requirement to report on all patients" via the all-payer eCQM system (*see related story, p. 9*). At the same time, the difficult 2022 MIPS targets will get participants looking harder — and maybe with relief — at alternatives.

"With penalties remaining high — up to a 9% penalty — those who have 'gotten by' in prior years are making a risky bet that the same strategy will clear the newly-raised bar," Halpert says.

Lauren Patrick, CEO of Healthmonix, says that MIPS participants "will be doubly surprised in 2022" because "many took the extreme and uncontrollable circumstances [MIPS exception] in 2020 and 2021," which insulated them from performance threshold changes. "During that time, the performance threshold went from 30 to 60 and it's going to 75 for 2022," she says.

In addition, "the opportunity to achieve the same scores as in prior years is waning. First, bonus points for high-priority and eCQM/end-to-end collection are removed," Patrick says. "Secondly, there are fewer measures, and the benchmarks for many measures are higher — hence it's more difficult to get the same decile score for individual measures. Thirdly, the Cost category will be worth 30% of the score and providers do not understand this category. If providers don't start early, they will have a very difficult time avoiding a penalty."

Plan ahead

Halpert suggests that you prepare for MVP insofar as possible now. For example, there will be a new registration process that will force some groups to report as smaller, specialty-specific groups to ensure that the measures are meaningful. For example, Halpert says, in a multispecialty group "the orthopedists will report one set of measures, while the anesthesiologists will report another." This will require a rethink in reporting because while under traditional MIPS "the group can pick and choose the most optimal — but not necessarily most meaningful — set of measures," MVP may force them to report measures in which they are not strong.

"In order to succeed then, providers and groups must establish a strategy now that gives them insights into their care and costs, with the ability to see the big picture and the flexibility to trace the effects of their overall strategy down to the individual patient level," Halpert says. — *Roy Edroso* (*redroso@decisionhealth.com*) ■

Shared Savings

Shared Savings ACOs get two years to brace for heavy APP, eCQM lift

CMS finalized the delay of controversial reporting changes for Shared Savings accountable care organizations (ACO), but stakeholders remain concerned that those changes will make the program significantly more difficult in the future.

The mandatory reporting of electronic clinical quality measures (eCQM) under the new Alternative Payment Model (APM) Performance Pathway (APP) that was slated to begin in 2022 under previous rule-making is delayed until 2025, according to the final 2022 Medicare physician fee schedule released Nov. 2 (*PBN 7/26/21*). eCQMs are extracted from the participant's EHR systems and include data not previously included in Medicare reporting, such as data from private insurers.

Participants who feel ready can get started now. But know the rules: Whenever you choose start, you will have to report three eCQMs or MIPS CQM measures; abandon the popular CMS Web Interface reporting method; and perform the CAHPS for MIPS survey. You will also have CMS report two administrative claims data measures on your behalf.

For those who wish to wait, you will report regular measures until 2025. The program performance threshold will be held at the 30th percentile through 2023. In 2024, it escalates to the 40th percentile.

Coming of eCQMs

Lauren Patrick, president and CEO of qualified registry Healthmonix in Malvern, Pa., says registries have been working with CMS for years on the development of eCQM reporting. "While we agree it is a large task to combine this data effectively across an ACO, and many EHRs present challenges in interoperability," Patrick thinks it's both necessary and doable. "If an ACO cannot combine data about a patient's A1c," she asks, "how are they managing that care?"

The delay until 2025 of mandatory eCQM reporting is probably a relief to many participants. But Ashley Ridlon, vice president of health policy at Evolent Health in Arlington, Va., says it will remain a heavy lift, and many participants in Shared Savings will find it a strain.

For one thing, the all-payer aspect could be a major challenge to ACOs with multiple entities with varying EHR systems and even different levels of technical sophistication. "Some providers might even still be on paper records," Ridlon says. Also, when reconciling multiple payer data points to report eCQMs, ACOs will have to "aggregate and de-duplicate data at the patient level," she says.

Ridlon explains: "ACOs simply cannot pull a ready-made file that aggregates the numerators and denominators for a measure."

If they do, "they risk double counting beneficiaries — for example, if that patient saw multiple providers in the ACO," Ridlon adds. "Two of the three eCQMs require that the most recent blood pressure or hemoglobin A1c be captured. The aggregate file does not cut it in this circumstance, because it does not reflect the most recent reading; thus, the ACO has to start with a more basic patient-level QRDA I file, and then roll that up into an aggregate QRDA III file. This is made more challenging without patient-level data from the private payers who contract with ACO-participating TINs separately."

If you are a single provider reporting quality in the MIPS program, reporting eCQMs is "pretty easy," Ridlon says. "You're the one who has the contracts with all the payers — Medicare, Medicaid and private payers — so you have that data. When you have a hospital system or even an integrated system, it may be a little harder, but at least you're probably on the same EHR system. When you have an ACO comprised of multiple entities with hundreds of individual TINs and dozens of EHRs, it gets a lot more difficult. The ACO doesn't hold the contracts with the payers."

Ultimately, Ridlon is concerned about the timeline providers face. "One year, two years, three years really isn't enough time to transition to all-payer eCQMs. I don't know if 10 years is enough time." Nonetheless, under the current rule, participants will have to do it in 2025.

Risk-scoring challenges

There have been complaints within the Shared Savings program about its risk-scoring methodology, which some participants consider insufficiently flexible, especially for ACOs that endeavor to serve sicker-than-average populations (*PBN 9/13/21*).

This year CMS isn't making any changes to it.

Patrick points out that CMS "solicited feedback on risk scoring and limits on risk-scoring adjustments through

the five-year period of an ACO's contract" and "received a wealth of comments." The agency finally decided in the rule to "take these comments into consideration as we contemplate additional refinements to the Shared Savings Program's benchmarking methodologies and … propose any specific policy changes, if deemed appropriate, in future notice and comment rulemaking."

While this delays a response to the concern, it does show that "CMS recognizes that this is an area where ACO's are requesting modifications in the rule," Patrick says.

The National Organization of Accountable Care Organizations (NAACOS) is not so sanguine. "We hope the agency will take action in rulemaking as soon as possible and not wait another full year," NAACOS said in a statement. "Specifically, NAACOS supports removing ACO-assigned beneficiaries from ACOs' regional reference populations and capping risk scores in an ACO's region at the same level of the ACO."

Note one big financial change for participants who accept performance-based risk in Shared Savings ACOs. They'll have to put up money — "escrow, line of credit, surety bond," per the rule — to assure CMS that they can repay losses for which they may be liable upon reconciliation. — *Roy Edroso* (redroso@decisionhealth.com) ■

Physician fee schedule

Fee schedule round-up: Conversion factor cut, PAs freed and more

The final CY2022 conversion factor, effective Jan. 1, falls about 4% to a rate of $33.59, down from $34.89 in 2021, according to the 2,414-page final rule released Nov. 2. The decrease is largely attributed to the end of the one-time payment increase that lawmakers authorized under the Consolidated Appropriations Act of 2021 (CAA) and comes despite intense lobbying by physician groups to stave off the year-to-year cuts.

"The PFS conversion factor reflects the statutory update of zero percent and the adjustment necessary to account for changes in relative value units and expenditures that would result from our finalized policies," CMS states in a fact sheet to the final rule.

The final conversion factor is up one cent from the proposed conversion factor of $33.58 announced in July.

The anesthesia conversion factor will be $20.93 in 2022, down a good deal from the proposed rate of $21.04 — and the 2021 rate of $21.56.

E/M and teaching physicians

CMS finalized changes for teaching physicians billing E/M services. When using time as the defining factor to select an office or outpatient visit, "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," CMS explains.

Note that under the so-called primary care exception, which allows for teaching physicians to bill for a resident-led encounter when the teaching physician is not physically present, only medical decision-making (MDM) — and not time — will be allowed for code level selection.

CMS slims therapy assistant reduction

A statutorily required 15% pay reduction for physical therapy assistants (PTA) and occupational therapy assistants (OTA) could apply to fewer encounters when it takes effect Jan. 1.

CMS has finalized its proposed policy to set a *de minimus* standard for timed therapy services that will allow full payment for cases when a PTA or OTA participates in providing care to a patient independent from the physical therapist/occupational therapist (PT/OT), but the PT/OT meets the Medicare billing requirements for the timed service on their own, without the minutes furnished by the PTA/OTA, by providing more than the 15-minute midpoint (that is, eight minutes or more).

The payment-reducing modifiers — **CQ** (Outpatient physical therapy services furnished in whole or in part by a physical therapist assistant) and **CO** (Outpatient occupational therapy services furnished in whole or in part by an occupational therapy assistant) — would not apply to such services. Also, in the limited cases when two 15-minute units of therapy remain to be billed when the therapist and assistant each provide between nine and 14 minutes of the same service, and the total time is at least 23 minutes but no more than 28 minutes. One of the units would be billed with the CQ/CO modifier and one without, under Medicare's finalized policy.

The CQ and CO modifiers — and reduced payments— would therefore apply in these cases:

- When the PTA/OTA independently provides a service or a 15-minute unit of a service "in whole" without any involvement by the PT/OT.
- For PTA/OTA involvement in services that are not defined in 15-minute increments, including supervised modalities; evaluations/reevaluations; and group therapy.
- When the PTA/OTA provides eight minutes or more of the final unit of a case in which the PT/OT does less than eight minutes of the same unit of service.
- When both the PTA/OTA and the PT/OT each furnish fewer than eight minutes of a final 15-minute unit of service during a patient encounter.

PAs approved for direct-billing

Under the change, mandated by the CAA, physician assistants (PA) will also be able to accept or reassign payment for their services. PAs working in all settings, in both rural and non-rural areas, will be able to take advantage of the new policy. However, as non-physician practitioners, PAs will continue to be paid at 85% of the physician allowable amount. They also will continue to be required to work under physician supervision.

Additional news and notes

- **Vaccine administration rates set**. While Part B payment under previous rulemaking for vaccines was supposed to be frozen at $16.94 for 2021, the COVID emergency led to a series of changes in COVID vaccination payments (*PBN 3/22/21*, *6/21/21*). In 2022, administration of COVID vaccines will pay $40 per dose through the end of the year the public health emergency (PHE) ends, at which time the fee will be reexamined. COVID-19 vaccine administration in the home under certain circumstances nets $35.50, and administration of COVID-19 monoclonal antibody products pays $450 in facility and $750 in the home, the fees to be reconsidered at the end of the last PHE year. Influenza, pneumococcal and hepatitis B virus vaccine administration will pay $30 per dose starting in 2022.

- **MNT, DSMT billing changes**. As of Jan. 1, medical nutrition therapy (MNT) services, for which beneficiaries with diabetes or a renal disease are eligible, will be paid at 100% of 85% of the Medicare-approved amount, rather than the previous 80% of 85%, and without cost-sharing. Also, patients can be referred to MNT by any M.D. or D.O., not solely the provider treating their condition; neither MNT nor diabetic self-management training (DSMT) may be furnished and billed incident to the professional services of a physician or practitioner; and both MNT and DSMT services may be provided as telehealth services, but only when registered dietitians or nutrition professionals "act as distant site practitioners," according to the final rule.

- **AUC still delayed**. Mandatory adoption of the appropriate use criteria (AUC) for imaging is, as proposed, delayed until "the later of January 1, 2023, or the January 1 that follows the declared end of the PHE for COVID-19," according to the final rule. CMS also makes some technical changes to criteria. For example, "when the furnishing professional performs additional imaging services not reflected on the order under these circumstances, we do not believe it would be appropriate to consider them to be acting as an ordering professional such that an AUC consultation would be needed."

- **More MDPP perks, payments**. CMS finalized several major changes for the Medicare Diabetes Prevention Program, including a waived enrollment fee for suppliers (normally $599) retroactive to Jan. 1, 2021; a reduction of the program length from two years to one year; and more payment for fewer sessions. The finalized changes sweeten the deal by raising the maximum amount suppliers can bill for one year if the beneficiary hits their 5% weight-loss targets to $705 rather than the proposed $661. A full two years of participation, which commenters told CMS hardly anyone achieved, had netted suppliers $704. If the beneficiary merely fulfills attendance target without the 5% weight loss, the supplier gets $455.

- **COVID-19 to be covered for pulmonary rehab**. Calling pulmonary rehabilitation services "severely underutilized" despite their delivery of "clear benefits on clinical and patient-centered outcomes," CMS confirmed that it is adding COVID-19 as a covered condition for the services. Effective Jan. 1, outpatient PR services can be furnished to patients with a confirmed or suspected COVID-19 case who experience respiratory dysfunction for at least four weeks. "To be clear, this includes beneficiaries regardless of whether they were hospitalized as this expanded coverage is agnostic to the setting in which they were treated," CMS states in the final rule. A positive COVID test is not required, and the four-week period can begin at the onset of symptoms, the agency clarified. CMS also is revising the regulatory text for PR services

to betting align its conditions of coverage with related cardiac rehabilitation (CR) and intensive CR services. Specifically, CMS is revising six PR definitions to align them with the CR services, including individualized treatment plan; medical director; outcomes assessment; physician-prescribed exercise; psychosocial assessment; and supervising physician.

- **CMS confirms payment limits for rural health clinics (RHC)**. The Consolidated Appropriations Act (CAA) of 2021 finalized payment limits for RHCs for the eight-year period from 2021 to 2028, and CMS rubberstamped the rates in the final rule. The national statutory payment limit, set at $100 after March 31, 2021, nearly doubles by the end of the eight-year window, when it reaches $190 per visit in 2028. In ensuing years, the payment limit will rise in accordance with the percentage increase in the Medicare Economic Index (MEI), according to CMS.
- **Rural, federal clinics can report dual care management services**. Both rural health clinics (RHC) and federally qualified health centers (FQHC) are eligible to report transitional care management (TCM) and other care management services, such as chronic care management (CCM), to the same patient during an overlapping timeframe, CMS confirmed in the final rule. That is, a clinic or center can furnish a TCM service even when a separate clinic or center has furnished a CCM service during the same period — "provided all requirements for billing each code are met," the agency states.
- **Virtual mental health services cleared for RHCs, FQHCs**. Mirroring the policy outlined for other Part B billing providers, rural health clinics (RHC) and federally qualified health centers (FQHC) will be allowed to conduct and report mental health services furnished via telehealth — that is, using real-time telecommunication technology — in 2022 and beyond. As with other providers, an exception exists. RHCs and FQHCs also will be eligible to report mental health services via audio-only means "when the beneficiary is not capable of, or does not consent to, the use of video technology," CMS states. Note that an in-person visit must be reported at least once during a 12-month period in order to bill the telehealth services. More frequent in-person visits are allowed under the policy.
- **A drug is a drug — or a biological**. Drug manufacturers without a Medicaid drug rebate agreement will be required to report average sales price (ASP) data to CMS starting Jan. 1, according to a revised policy that CMS is implementing at the behest of the Consolidated Appropriations Act (CAA) of 2021. As part of the revised policy, which previously allowed manufacturers without a drug rebate agreement to report the ASP voluntarily, CMS is codifying a new definition of "drug" to mean "a drug or biological, and includes an item, service, supply or product that is payable under Medicare Part B as a drug or biological." The reporting requirement specifically does not exclude drug repackagers.
- **Supply and equipment pricing update is complete**. CY2022 will be the fourth and final year of the market-based supply and equipment pricing update that has gradually phased in revised payments involving direct practice expenses. Moving from a 25% share of new pricing in 2019 to a 100% share in 2022, the four-year phase-in sets the final price of supplies going forward, pending individual review during the annual physician fee schedule rulemaking period. The complete list of CY2022 pricing updates is available as a download on the final 2022 fee schedule public use files page. See the "CY2022 PFS Final Rule Market-Based Supply and Equipment Pricing Update (ZIP)" file: *www.cms.gov/medicaremedicare-fee-service-paymentphysicianfeeschedpfs-federal-regulation-notices/cms-1751-f.*
- **CMS finalized its plan to remove two aged and out-of-date national coverage decisions (NCD)**. They are NCD 180.2 Enteral and Parenteral Nutritional Therapy (effective July 11, 1984) and NCD 220.6 Positron Emission Tomography (PET) Scans (Sept. 3, 2013). Removing the policies "better serves the needs of the Medicare program and its beneficiaries," the agency stated in the final rule.
- **E-prescribing for opioids**. CMS will delay the compliance deadline for electronic prescriptions for opioids covered by Part D again. The new compliance deadline for most prescriptions is Jan. 1, 2023. Prescriptions for patients in long-term care facilities won't need to comply until Jan. 1, 2025. — *DecisionHealth staff* (*pbnfeedback@decisionhealth.com*) ■