HEALTHCARE REGULATORY ROUND-UP

Highlights from the 2022 Medicare Physician Fee Schedule Final Rule

November 18, 2021

Introductions

Martie Ross
mross@pyapc.com

Lori Foley
acaldwell@pyapc.com

Valerie Rock
vrock@pyapc.com

PYA

pyapc.com
800.270.9629

ATLANTA | KANSAS CITY | KNOXVILLE | NASHVILLE | TAMPA

Agenda

1. Part B monthly premium and deductible
2. Conversion factor
3. New telehealth services
4. New coverage for tele-behavioral health services
5. E/M changes (split/shared billing, critical care, teaching physicians)
6. Billing for PA services
7. Appropriate use criteria
8. Medicare Diabetes Prevention Program
9. Remote patient monitoring
10. Increased reimbursement for care management services
11. Quality Payment Program updates

1. Part B Monthly Premium & Deductible

- Standard premium = 25% program costs
  - Higher income individuals pay higher percentage
- 2022 standard premium = $170.10; 13% increase over 2021
  - ~ half of increase attributable to cost of new Alzheimer's drug, Aduhelm
- 2022 deductible = $233; 13% increase over 2021
- For most seniors, increase offset by 5.9% COLA for Social Security benefits

2. Conversion Factor

- A bit of history –
  - 2019 to 2020: $.05 increase ($36.04 to $36.09)
  - 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
- CY2022 – $33.59 (3.75% reduction)
  - Statutory update of zero percent
  - Adjustment necessary to account for changes in RVUs and expenditures resulting from finalized policies
- Practice expense adjustments
  - Standard rate-setting refinements
  - Market-based supply and equipment pricing update
  - Clinical labor pricing update

3. List of Telehealth Services

- Section 1834(m) –Medicare telehealth coverage
  - Location (originating site – not beneficiary's home)
  - Geography (non-MSA)
  - 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

- PHE-designated services for which coverage will continue through December 31, 2023
- List available at https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes
- Added cardiac and intensive cardiac rehabilitation services (CPT 93797-98, G0422-23)

4. 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 practitioner in same practice as billing practitioner within 6 months prior to initial telehealth service + each 12 months thereafter
  - Exceptions to the in-person visit requirement may be made based on beneficiary circumstances (with reason documented in beneficiary's medical record)
- May use audio-only communication technology (vs. audio/video required for other telehealth services) but only if -
  - Practitioner has audio/video capability + beneficiary lacks capacity or refuses to use video connection
    - Documented in medical record + include service-level modifier on claim

5. E/M Changes – Split/Shared E/M Visits

- E/M services provided in facility setting by physician and NPP in same group
  - Includes new/established patients, initial/subsequent visits, prolonged visits, critical care services
  - Follow ‘incident to’ rules in office setting
- Bill under NPI of individual who performed the “substantive portion” of the service
  - For 2022, based either on who performed (1) key components (history, exam, medical decision-making) in their entirety, or (2) who spent more than half the total time furnishing the service
    - Except critical care, which must be based solely on time
  - For 2023, all E/M services based solely on time

5. E/M Changes – Critical Care Services

- May be provided concurrently to same patient/same day by more than one practitioner representing more than one specialty
- May be paid on same day as other E/M visit by same practitioner (or another practitioner in same group of same specialty), but only if –
  - Practitioner documents that E/M visit was provided prior to critical care service when patient did not require critical care
  - E/M visit was medically necessary
  - E/M visit was separate and distinct, with no duplicative elements from critical care service
  - Critical care service reported on claim with modifier -25
- May be paid separately in addition to procedure with global surgical period if the critical care is unrelated to surgical procedure (above and beyond and unrelated to specific anatomic injury or general surgical procedure performed)
  - New modifier to indicate critical care unrelated to procedure

5. E/M Changes – Teaching Physician

- When time used to select office E/M visit level, only time spent by teaching physician in qualifying activities (incl. time that teaching physician was present with resident performing those activities) can be included for purposes of visit level selection.
- For primary care exception, may only use MDM (not time) in determining E/M level (to avoid billing higher level based on residents' inefficiencies)

6. Billing for PA Services

- Currently, physician assistants cannot directly bill Medicare; services must be billed by PA's employer
- Consolidated Appropriations Act 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 finalizing regulatory amendments consistent with CAA provisions

7. Appropriate Use Criteria

- Created by Protecting Access to Medicare Act of 2014 (PAMA) to address perceived overuse of advanced diagnostic imaging (ADI)
- Requires that the ordering professional consult a clinical decision support mechanism (CDSM) prior to ordering ADI (vs. prior authorization)
  - CY2019 PFS final rule allows consultations by clinical staff under the direction of the ordering professional
- Payment penalty phase of AUC program delayed to January 1, 2023, or the January 1 that follows end of COVID-19 PHE
  - No payment to *furnishing provider* on claims that do not include specific new information about the *ordering* provider's AUC consultation process
- Legislative relief on the horizon?
  - In July, House Appropriations Committee directed CMS to submit a report on the success and challenges of the AUC program

8. Diabetes Prevention Program

- 16.4 million beneficiaries eligible for MDPP, less than 4,000 participating
  - Only 27% of eligible organizations participating

Payment Description	Current	Proposed	Final
Core Sessions (Months 1-6)			
Attend 1 Core Session or Bridge Payment	$26	$26	$35
Attend 4 Core Sessions	$52	$78	$105
Attend 9 Core Sessions	$95	$130	$175
Core Maintenance (CM) Sessions (Months 7-12)			
Attend 2 Core Maintenance Sessions (No 5% WL) in CM Interval 1 (Months 7-9)	$15	$52	$75
Attend 2 Core Maintenance Sessions (5% WL) in CM Interval 1 (Months 7-9)	$63	$106	$93
Attend 2 Core Maintenance Sessions (No 5% WL) in CM Interval 2 (Months 10-12)	$15	$52	$75
Attend 2 Core Maintenance Sessions (5% WL) in CM Interval 2 (Months 10-12)	$63	$106	$93
5% WL Achieved from baseline weight	$169	$189	$169
9% WL Achieved from baseline weight	$26	$26	$35
Ongoing Maintenance Sessions (Months 13-24)			
Attend 2 Ongoing Maintenance (OM) Sessions in OM Interval 1 (Months 13-15)	$52		
Attend 2 Ongoing Maintenance Sessions in OM Interval 2 (Months 16-18)	$52		
Attend 2 Ongoing Maintenance Sessions in OM Interval 3 (Months 19-21)	$53		
Attend 2 Ongoing Maintenance Sessions in OM Interval 4 (Months (22-24)	$53		
Subtotal Maximum Payment – Attendance Only	**$203**	**$338**	**$455**
Total Maximum Payment*	**$704**	**$661**	**$705**

9. Remote Patient Monitoring

Remote Physiologic Monitoring

Code	Descriptor	2021 Payment	2022 Payment	Difference
99453	Service initiation	$19.19	$18.48	-$0.71
99454	Monthly data transmission	$63.16	$54.10	-$9.06
99091	Interpretation and analysis, 30 min.	$56.88	$54.77	-$2.11
99457	Treatment management services, 20 min.	$50.94	$48.72	-$2.22
99458	Treatment management services, +20 min.	$41.17	$39.65	-$1.52

Remote Therapeutic Monitoring

Code	Descriptor	2022 Payment
98975	Service initiation	$18.81
98976	Monthly data transmission–respiratory system	$54.10
98977	Monthly data transmission–musculoskeletal system	$54.10
98980	Treatment management services, 20 min.	$48.72
98981	Treatment management services, +20 min.	$39.65

Defining RTM

- Requires use of device that meets FDA definition of “medical device”
- Data can be self-reported by patient
- No specific reference to minimum of 16 days’ data
- CPT 98980 and 98981 are not designated as care management services assigned to general supervision (i.e., require direct supervision of clinical staff)
- General medicine codes that can be billed by providers who cannot bill for E/M
  - “where the practitioner’s Medicare benefit does not include services furnished incident to their professional services, [RTM services] must be furnished directly by the billing practitioner or, in the case of a PT or OT, by a therapy assistant under the PT’s or OT’s supervision

10. Care Management Services

Code	Descriptor	2021 Payment	2022 Payment	Difference
99490	CCM, clinical staff, initial 20 min.	$41.17	$62.16	+$20.99
99439	CCM, clinical staff, +20 min.	$37.69	$47.04	+$9.35
99491	CCM, physician/NPP, 30 min.	$82.53	$83.66	+$1.13
99437	CCM, physician/NPP, +30 min.	n/a	$59.47	n/a
99487	Complex CCM, clinical staff, 60 min.	$91.77	$130.37	+$38.60
99489	Complex CCM, clinical staff, +30 min.	$43.97	$68.51	+$24.54
99424	PCM, physician/NPP, 30 min.	$90.37	$80.98	-$9.39
99425	PCM, physician/NPP, +30 min.	n/a	$58.46	n/a
99426	PCM, clinical staff, 30 min.	$38.73	$61.49	+22.76
99427	PCM, clinical staff, +30 min.	n/a	$47.04	n/a
G0511	Care mgt., RHC/FQHC*	$65.24	$76.94	+$11.70

11. Quality Payment Program (MIPS)

- 2022 Performance Period
  - 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%)
  - Final year of exceptional performance bonus
- Quality –
  - Eliminating bonus points for end to end reporting and high priority measures; elimination of 3-point floor deferred to 2023 with exceptions for small practices
  - Continue CMS Web Interface for 2022 PY
  - Update measures (200 measures for 2022 PY)
  - Did not finalize the proposed increase data completeness requirement to 80% for 2023 PY; will retain current 70%
  - Did not finalize use of alternate benchmarks for 2022 PY; will use 2020 data for benchmarks

Quality Payment Program (MIPS)

- **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
    - Require attestation of annual completion of High-Priority Guide on the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)
    - Modify Information Blocking attestations to differentiate from ONC requirements in 21st Century Cures Act
    - Revise reporting requirements to support public health agencies (PHAs) during future health threats and the long-term COVID-19 recovery process.
    - Added a 4th exclusion for the Electronic Case Reporting measure (2022 only)
    - Did not finalize requirement that patients can access their health information indefinitely for encounters after 1/1/16

Quality Payment Program (MIPS)

- 2022 Performance Period
  - Continuing complex patient bonus – capped at 10 points added to the final score with some modifications to the formula
  - 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

MIPS Value Pathways (MVPs)

- 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 - 2025 for individual clinicians, single/multispecialty groups, subgroups and APM entities on an MVP for all MIPS categories; currently 7 MVP groupings
  - PY 2026 – 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

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, one must be an outcome measure (or a high priority measure if an outcome is not available or applicable). 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: • Two medium weighted improvement activities **OR** one high weighted improvement activity **OR** IA_PCMH (participation in a PCMH), if the activity is available in the MVP	An MVP Participant is scored on the cost measures included in the MVP that they select and report.

FOUNDATIONAL LAYER (MVP AGNOSTIC)

Population Health Measures*
An MVP Participant selects one population health measure, at the time of MVP registration, to be scored on. The results are added to the quality performance category score.

Promoting Interoperability Performance Category
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.

How can we HELP?

A national healthcare advisory services firm providing consulting, audit, and tax services