



CY 2022 Medicare Physician Fee Schedule (PFS) and Quality Payment Program (QPP) Final Rule Summary

OVERVIEW

On November 3, 2021, the Centers for Medicare and Medicaid Services (CMS) released the **Medicare Program; CY 2022 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Provider Enrollment Regulation Updates; and Provider and Supplier Prepayment and Post-payment Medical Review Requirements** [final rule](#) (scheduled to publish in the Federal Register on November 19, 2021 – Document number 2021-23972). In addition, CMS published an accompanying [press release](#) and [fact sheet](#) highlighting the key provisions contained in the final rule. The policies in the rule are scheduled to take effect on January 1, 2022 and cover diverse topics, including the CY 2022 rate setting and Medicare conversion factor, telehealth and other services involving communications technology, and updates to the Quality Payment Program (QPP) through Merit-based Incentive Payment System (MIPS) activities, methodology, and payment adjustments, amongst other provisions. Below is a summary of select provisions finalized in the rule. The American Medical Association (AMA) continues to review and analyze the impact of key provisions contained in the final rule.

Executive Summary

- The final conversion factor for 2022 is \$33.5983, which reflects the expiration of the 3.75 percent increase for services furnished in 2021, the 0.00 percent update adjustment factor specified under section 1848(d)(19) of the Act, and a budget neutrality adjustment of -0.10 percent.
- For the 2022 PFS, the RUC submitted 185 recommendations for individual CPT codes. CMS implemented the recommended work values for 77% of these services and nearly all of the direct practice expense recommendations.
- CY 2022 will be the final year of transition to the new CMS prices for medical supplies and equipment.
- For 2022, CMS will implement new wage data from the United States Bureau of Labor Statistics and will update clinical labor costs over a four-year transition period.
- CMS finalized a split (or shared) visit as an E/M visit in the facility setting, for which “incident to” payment is not available when services are performed in part by both a physician and a non-physician practitioner (NPP).
- CMS will continue to pay for services placed temporarily on the telehealth list through the end of 2023.
- CMS will implement a recent change to Section 1834(m) which removes geographic restrictions and permits the home as an originating site for telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder.

- CMS finalized its proposal to delay enforcement of the Appropriate Use Criteria (AUC) program by at least one year until the later of January 1, 2023, or in January after the end of the public health emergency (PHE).
- CMS finalized its proposal to allow patients receiving treatment at OTPs to receive counseling and therapy services via audio-only telephone and simplified the administrative requirements for OTPs to document the use of audio-only telephone for provision of counseling and therapy services.
- Despite concerns from the AMA, CMS is ending coverage for audio-only E/M services (CPT codes 99441-99443) at the end of the PHE.
- CMS is covering the family of 5 RTM codes as general medicine codes, allowing physicians and other qualified health professionals to bill at their recommended RUC valuation. CMS also designated these codes as “sometimes therapy” codes, which allows use of these codes outside a therapy plan of care when provided by a physician and certain NPPs in appropriate circumstances.
- Beginning January 1, 2022, Physician Assistants (PAs) will be authorized to bill the Medicare program and will be paid directly for their services in the same as nurse practitioners (NPs) and clinical nurse specialists (CNSs).
- CMS finalized revisions to the *de minimis* policy previously finalized in the CY 2020 PFS final rule which delineates when the -CQ and -CO modifiers apply.

I. CALENDAR YEAR 2022 UPDATES FROM THE PHYSICIAN FEE SCHEDULE (PFS)

CY 2022 PFS Rate Setting and Medicare Conversion Factor

The final conversion factor for 2022 is \$33.5983, which reflects the expiration of the 3.75 percent increase for services furnished in 2021, the 0.00 percent update adjustment factor specified under section 1848(d)(19) of the Act, and a budget neutrality adjustment of -0.10 percent. The finalized CY 2022 anesthesia conversion factor is \$20.9343, a decrease of \$0.6257 from the CY 2021 anesthesia conversion factor of \$21.5600.

Coding Changes and Work Relative Values

Over the last 31 years, the AMA/Specialty Society Relative Value Scale Update Committee (RUC) has reviewed nearly all services paid through the PFS, accounting for 98% of spending. For the 2022 PFS, the RUC submitted 185 recommendations for individual CPT codes. CMS implemented the recommended work values for 77% of these services and nearly all of the direct practice expense recommendations. The services for which the RUC made recommendations for the CY 2022 payment schedule included principal care management, chronic care management, remote therapeutic monitoring, anesthesia services for image-guided spinal procedures, cataract surgery and cardiac ablation. CY 2022 will be the final year of transition to the new CMS prices for medical supplies and equipment.

The RUC recommendations, minutes, voting records, and other supporting documentation are available at www.ama-assn.org/about/rvs-update-committee-ruc/ruc-recommendations-minutes-voting.

Clinical Labor Pricing Update

CMS finalized the phased-in implementation of the clinical labor update over 4 years to transition from the current prices to the final updated prices in 2025. Clinical labor rates were last updated in 2002 using Bureau of Labor Statistics (BLS) data and other supplementary sources when BLS data points were not available. CMS finalized provisions to update the clinical labor rates in conjunction with the final year of the supply and equipment pricing update. This multi-year implementation aims to address concerns that current wage rates are inadequate, do not reflect current labor rate information, and that updating the supply and equipment pricing without updating the clinical labor pricing creates distortions in the allocation of direct PE. CMS provides an example of how this transition will be implemented in Table 10 in the final rule (shown below).

TABLE 10: Example of Clinical Labor Pricing Transition

Current Price	\$1.00	
Final Price	\$2.00	
Year 1 (CY 2022) Price	\$1.25	1/4 difference between \$1.00 and \$2.00
Year 2 (CY 2023) Price	\$1.50	1/3 difference between \$1.25 and \$2.00
Year 3 (CY 2024) Price	\$1.75	1/2 difference between \$1.50 and \$2.00
Final (CY 2025) Price	\$2.00	

CMS also make additional technical changes to how the rates are calculated and how certain clinical labor types are priced when BLS data were not available. CMS will use the median BLS wage data rather than the proposed average or mean wage data for calculation of clinical labor rates.

The updated data significantly increases the overall pool of direct costs. The direct practice expense data within the PFS is a fixed pool of resources, and therefore implementation of these increased costs result in a redistribution. The total direct practice expense pool increases by 30 percent under this proposal, resulting in a significant budget neutrality adjustment. Specialties that rely primarily on clinical labor rather than supply or equipment will receive the largest increases relative to other specialties. In contrast, specialties that rely primarily on supply or equipment items are anticipated to receive the largest decreases relative to other specialties. These payment impacts, however, **do not** show the impact of the expiration of the 3.75 percent increase to PFS payments for 2021 from the Consolidated Appropriations Act. Thus, the combined effect of RVU changes and the conversion factor is likely much larger than these impacts.

The finalized clinical labor prices are shown in Table 12 of the rule.

Comment Solicitation for Impact of Infectious Disease on Codes and Rate Setting

During the COVID-19 PHE, CMS heard stakeholders' concerns regarding additional costs borne by physicians due to the pandemic that may impact the professional services furnished to Medicare beneficiaries. In the CY 2022 proposed rule, CMS sought comments on whether Medicare should make changes to payments for services or develop separate payments to account for PHE-related costs, such as disease control measures, research-related activities and services, or PHE-related preventive or therapeutic counseling services. In comments on the proposed rule, the AMA reiterated the need for CMS to adopt CPT code 99072. The AMA and

127 state medical and national specialty societies have [urged](#) CMS to implement and pay for CPT code 99072 *Additional supplies, materials, and clinical staff time over and above those usually included in an office visit or other non-facility service(s), when performed during a Public Health Emergency, as defined by law, due to respiratory-transmitted infectious disease* to compensate physician practices for the additional supplies and new staff activities required in order to provide safe patient care during the COVID-19 PHE without patient cost-sharing. In the final rule, CMS states that it will consider the comments received in future rulemaking.

Evaluation and Management (E/M) Services

Effective January 1, 2021, CMS implemented sweeping revisions to office and outpatient E/M visits as recommended by the CPT Editorial Panel and the RUC, which allow physicians to bill the E/M visit level based on either total time spent on the date of patient encounter or the medical decision making utilized in the provision of the visit. Due to these changes and recent withdrawal of guidance in the Medicare Claims Policy Manual, CMS reviewed other E/M visit code sets and finalized clarifications regarding split (or shared) visits, critical care services, and teaching physician visits.

Split/Shared Visits

A split (or shared visit) refers to an E/M visit performed (split or shared) by both a physician and a NPP who are in the same practice group. The Medicare statute provides a higher PFS payment rate for services furnished by physicians than those same services furnished by NPPs. For visits in the non-facility (e.g., office) setting, when an E/M visit is performed in part by a physician and a NPP, the physician is permitted to bill for the visit as long as the visits meets the conditions for services furnished “incident to” a physician’s professional services.

CMS defines a split (or shared) visit as an E/M visit in the facility setting, for which “incident to” payment is not available, and that is performed in part by both a physician and a non-physician practitioner (NPP). Only the physician or NPP who performs the substantive portion of the split (or shared) visit would bill for the visit. CMS defines “substantive portion” as more than half of the total time spent by the physician and NPP. CMS also modified its existing policy and now will allow either physicians or NPPs to bill for split (or shared) visits for both new and established patients, for critical care and certain Skilled Nursing Facility/Nursing Facility (SNF/NF) E/M visits. CMS also notes that Medicare does not pay for partial E/M visits. CMS requires a modifier be utilized to designate these split (or shared) visits in claims data.

Critical Care Services (CPT codes 99291-99292)

CMS finalized the adoption of the CPT prefatory language for critical care services as currently described in the CPT Guidelines. CMS prohibits a practitioner that reports critical care services furnished to a patient from also reporting any other E/M visit for the same patient on the same calendar day that the critical care services are furnished to that patient and vice versa. Additionally, CMS would prohibit billing critical care visits during the same time as a procedure with a global surgical period.

Teaching Physician Visits

CMS finalized that when total time is used to determine the office/outpatient E/M visit level, only the time that the teaching physician is present can be included. In response to comments,

CMS clarified that only time spent by the teaching physician performing qualifying activities listed by CPT (with or without direct patient contact on the date of the encounter), including time the teaching physician is present when the resident is performing those activities, may be counted for purposes of the visit level selection. This time excludes teaching time that is general and not limited to discussion that is required for the management of a specific patient.

Telehealth and Other Services Involving Communications Technology

Retention of Category 3 Services Through the End of 2023

In the [CY 2021 PFS final rule](#) (85 FR 84507), CMS created a third category for the Medicare telehealth services, referred to as Category 3. This new category describes services that were added to the Medicare telehealth services list during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but there is not sufficient evidence on these services available to consider adding the services under the Category 1 or Category 2 criteria. Services added as a Category 3 telehealth service would ultimately need to meet the Category 1 or Category 2 criteria to be permanently added to the telehealth service list.¹

CMS will continue to pay for services placed temporarily on the telehealth list through the end of 2023. This proposal is consistent with AMA's advocacy that CMS maintain Medicare coverage and payment for the many services that were temporarily added to the Medicare telehealth list during the PHE for two years after the PHE ends in order to provide more time to evaluate whether these services should be permanently added to the telehealth list once the COVID-19 PHE is declared over.

In response to concerns about the uncertainty about when the PHE may end, CMS finalized its proposal to revise the timeframe for inclusion of the services added to the Medicare telehealth list on a Category 3 basis until the end of 2023. CMS believes this will allow additional time for stakeholders to collect, analyze and submit data to support their consideration for permanent addition to the list on a Category 1 or Category 2 basis.

Telehealth and Audio Only for Mental Health Services

CMS is implementing a recent change to Section 1834(m) which removes geographic restrictions and permits the home as an originating site for telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, so long as the practitioner has provided these services to the patient in person within the last 6 months. CMS will require that an in-person, non-telehealth service must be furnished by the physician or practitioner at least once within 12 months of the telehealth service furnished for the diagnosis, evaluation, or treatment of mental health disorders with exceptions for circumstances where the physician and patient agree that the benefits of an in-person visit are outweighed by the risks and burdens associated with an in-person service. Required in-person visits may be performed by another physician or practitioner of the same specialty and subspecialty in the same group as the practitioner who furnishes the mental health telehealth service to the beneficiary if the practitioner who furnishes the telehealth service is unavailable.

¹ The Medicare telehealth services list is available on the CMS website at <https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/index.html>. Information about submitting a request to add services to the Medicare telehealth services list is also available on this website.

CMS is also revising its regulatory definition of “interactive telecommunications system” to permit use of audio-only communications technology for mental health telehealth services under certain conditions when provided to beneficiaries located in their home. Coverage will be limited to physicians who have capability to furnish two-way audio-visual services, but coverage will be provided where the beneficiary is unable to use, does not wish to use, or does not have access to two-way, audio/video technology.

Audio Only for Other Services

CMS is ending coverage for audio-only E/M services (CPT codes 99441-99443) at the end of the PHE. The AMA vigorously opposed this policy in the proposed rule and sought for coverage to extend at least to the end of 2023, along with other temporarily covered telehealth services.

Clarification of CMS’ Definition of “Home” in 1834(m)

CMS clarified that it defines “home” for purposes of 1834(m)(4)(C)(ii)(X) expansively to include temporary lodging such as hotels and homeless shelters. It also includes situations in which a patient “chooses to travel a short distance from the exact home location during a telehealth service.” The AMA has strongly advocated to allow for patients to access telehealth services from wherever they are located.

Expiration of PHE Flexibilities for Direct Supervision Requirements

Prior to the PHE, direct supervision of diagnostic tests, services incident to physician services, and other specified services required the immediate availability of the supervising physician or other practitioner. CMS interpreted this “immediate availability” to mean in-person, physical availability and not virtual availability. During the PHE, CMS changed the definition of “direct supervision” to allow the supervising professional to be immediately available through a virtual presence using real-time audio/video technology for the direct supervision of diagnostic tests, physicians’ services and some hospital outpatient services. CMS finalized continuation of this policy through the end of the year in which the PHE ends or December 31, 2021.

CMS notes this temporary exception to allow immediate availability for direct supervision through a virtual presence also facilitates the provision of telehealth services by clinical staff of physicians and other clinicians incident to their own professional services. This allowed PT, OT, and SLP services provided incident to a physician to be provided and reimbursed.

In the proposed rule, CMS solicited comments on the following:

- Should the timeframe for the flexibility of direct supervision be extended beyond the PHE to facilitate obtaining additional information about the implications of a permanent policy change?
- If the policy was made permanent, should this be allowed only for a subset of services as there may be potential patient safety concerns if the physician is not immediately available in-person?
- If the policy was made permanent, should a service level modifier be required to identify when the requirement for direct supervision were met using two-way, audio/video communications technology?

The AMA, along with several other commenters, recommended that the policy be made permanent or, at a minimum, extend through the end of 2023 consistent with the policy for Category 3 telehealth services. The AMA supports the current policy during the COVID-19 PHE allowing “direct supervision” to include immediate availability through the virtual presence of the supervising physician using real-time, interactive audio/video communications technology be made permanent, or at a minimum, the current policy should be continued through 2023 as is proposed for Category 3 Medicare telehealth services. The fact that remote supervision may be inappropriate in some cases does not justify refusing to pay for it under any circumstance. In many rural and underserved areas patients may be unable to access important services if the only physician available has to supervise or deliver services at multiple locations and may not be available to supervise services when all patients need them. Failure to allow remote direct supervision can mean that a patient would be unable to receive the service at all, rather than forcing in-person supervision to occur. Both patients and CMS rely on physicians’ professional judgment to determine the most appropriate services to deliver, and the same principle should apply to how supervision is provided. In the final rule, CMS indicated that it will consider these comments in future rulemaking.

Remote Therapeutic Monitoring (RTM)

The RTM codes is a family of five codes that includes three PE-only codes and two codes that include professional work. In the proposed rule, CMS noted the new five RTM codes have similar services and code structure as the existing seven Remote Physiological Monitoring (RPM) codes. CMS discussed two primary differences: (1) according to RUC documents, primary billers of RTM codes are projected to be nurses and physical therapists and are considered general medicine codes (RPM services are considered to be E/M codes) and (2) RTM codes monitor health conditions and allow non-physiologic data collected.

CMS is covering the family of 5 RTM codes as general medicine codes, allowing for physicians and other qualified health professionals to bill at their recommended RUC valuation. CMS is also designating these codes as “sometimes therapy” codes, which allows for them to be billed outside a therapy plan of care when provided by a physician and certain NPPs in appropriate circumstances. CMS also stated it would like to engage in discussions with AMA CPT “in the immediate future” about how best to refine RTM codes to address the concerns of certain commenters.

Innovative Technology and Artificial Intelligence (AI) Request for Information (RFI)

In the finalized rule, CMS addressed feedback on a variety of questions it issued regarding coverage of AI and other innovative technologies, focusing on how best to value the direct and indirect costs related to services incorporating these technologies. Overall, commenters were appreciative of CMS’ effort to understand and proactively engage on AI topics as well as the acknowledgement that these are not well accounted for in the current PE methodology. While CMS did not make any changes based on this feedback, it will consider these comments in future rules or guidance.

Medicare Diabetes Prevention Program Expanded Model (MDPP)

CMS is finalized several significant changes to the Medicare Diabetes Prevention Program (MDPP). In our comments, the AMA supported all of the changes made. CMS eliminated the

ongoing maintenance sessions (year 2) from Medicare DPP for beneficiaries who start their MDPP on or after January 1, 2022. (§ 410.79) Consistent with the emergency MDPP policy precipitated by the COVID-19 PHE, Medicare DPP beneficiaries who began the program in 2021 or who were in ongoing maintenance classes in 2021 will have the option of accessing year 2 or not. In tandem with the elimination of year 2, CMS finalized the redistribution of all the payment from the ongoing maintenance sessions to the core and core maintenance session performance payments. (§ 414.84) The total available payment amount for 2022 is \$705. The Medicare provider enrollment application fee (\$599) is waived for all organizations applying to be a MDPP supplier, effective January 1, 2022. (§ 424.205).

CMS believes that taken together, these changes in the final rule will increase the number of MDPP suppliers, which will increase beneficiary access to MDPP services, and result in an ongoing reduction of the incidence of diabetes in eligible Medicare beneficiaries, in both urban and rural communities. The AMA hopes these changes will indeed lead to greater MDPP supplier enrollment, and ultimately greater Medicare beneficiaries participating in the MDPP.

The AMA advocated for additional changes to the program, however several of our recommendations were not included in the final rule. The once per lifetime limitation in the MDPP remains in place. The high-risk designation requirements for DPP suppliers enrolling in Medicare continue. Virtual DPP is not extended beyond the COVID-19 PHE. CMS declined to make risk-adjusted payments, citing it too complicated and the small cohort size, to address barriers such as transportation and other social determinants. CMS did not, however, this will be considered for future rulemaking. Finally, CMS did not make additional adjustments to align MDPP eligibility standards with the CDC's DPRP standards.

Appropriate Use Criteria

As [urged](#) by the AMA, CMS finalized its proposal to delay enforcement of the Appropriate Use Criteria (AUC) program by at least one year until the later of January 1, 2023, or the January 1 that follows the end of the PHE. The AUC program requires ordering physicians to consult appropriate use criteria using a clinical decision support mechanism prior to ordering advanced imaging services for Medicare beneficiaries and furnishing physicians to report this information on the claim. Previously, CMS was scheduled to begin denying claims that do not report AUC information on January 1, 2022. The finalized delay recognizes the significant disruptions caused by the COVID-19 pandemic and will allow more time for the education and operations testing period, which is critical given CMS' finding that only 9-10 percent of 2020 diagnostic imaging claims would have met the AUC reporting requirements to be paid if enforcement had been in effect. The final rule also acknowledges the complexity of the AUC program and CMS states that it will continue to explore opportunities for reducing the burden of the AUC program. This AMA [webpage](#) provides additional information about the AUC program and reporting requirements.

Electronic Prescribing of Controlled Substances (EPCS)

The SUPPORT Act required that Medicare Part D prescriptions for controlled substances be prescribed electronically starting on January 1, 2021, and also required the Drug Enforcement

Administration (DEA) modify the biometric component of the multifactor authentication requirements within its EPCS standards. The DEA has not yet revised these standards. CMS is also required to specify circumstances when the EPCS requirement may be waived, establish exceptions to the requirement, and determine penalties for non-compliance. CMS continues to encourage EPCS adoption and notes that EPCS increased from 38 percent of prescriptions in 2019 to 70 percent in 2021. The final rule pushes back the deadline for EPCS compliance until no earlier than January 1, 2023. For patients in long-term care facilities, the compliance deadline will be 2025. CMS also finalized that the threshold prescribers would need to meet for compliance is 70 percent of their Part D controlled substances being e-prescribed. CMS also finalized exceptions and waivers from the requirement, for example, for those who issue 100 or fewer Part D controlled substance prescriptions annually, those in disaster areas, as well as those who request and receive from CMS a waiver due to circumstances that prevent EPCS such as lack of broadband access. CMS also finalized its proposed policy that prescribers not in compliance by the deadline will be sent a letter advising of the need to comply but no penalties will be imposed.

Chronic Pain Management

CMS sought comments on whether it should create separate coding and payment for chronic pain management and achieving safe, effective dose reduction of opioid medications when appropriate, or whether these services are already appropriately recognized in the payment system. CMS cited multiple federal reports that urge better support for person-centered pain management, including the 2016 National Pain Strategy and the 2019 HHS Pain Management Best Practices Inter-Agency Task Force Report. It also noted the intersection between the problems with pain care and the worsening epidemic of drug overdose deaths, primarily due to illicitly manufactured fentanyl, other synthetic opioids, and methamphetamine. CMS also noted that untreated and inappropriately treated pain may translate to increased Medicare costs as more patients experience functional decline, incapacitation, and frailty. AMA comments supported patient-centered management of pain by clarifying, communicating, modifying, and/or expanding existing care management codes as needed to include patients with chronic pain and significant acute pain, in addition to patients with chronic diseases. The final rule indicates that CMS will consider these issues in future rulemaking.

Services Furnished by Opioid Treatment Programs (OTPs)

CMS has been allowing OTPs to be compensated for providing patients being treated for opioid use disorder with a take-home supply of nasal naloxone. As the Food and Drug Administration has now approved a higher strength nasal naloxone spray with 8mg of naloxone, CMS finalized the creation of a new code describing a take-home supply of the higher dose product. AMA comments underscored that the evolution of the drug overdose epidemic with many patients experiencing overdoses from illicitly manufactured fentanyl makes it important for patients to have access to the new, more potent overdose reversal drug. CMS also finalized its proposal to allow patients receiving treatment at OTPs to receive counseling and therapy services via audio-only telephone. The AMA believes it is vitally important to continue to provide patients with access to services. In addition, as the AMA had recommended, CMS simplified the administrative requirements for OTPs to document the use of audio-only telephone for provision of counseling and therapy services.

Billing for Physician Assistant Services

Section 403 of the Consolidated Appropriations Act (CAA) of 2021 amends section 1842(b)(6)(C)(i) of the Act to remove the requirement to make payment for physician assistant (PA) services only to the employer of a PA effective January 1, 2022. With the removal of this requirement, PAs will be authorized to bill the Medicare program and be paid directly for their services in the same way that nurse practitioners (NPs) and clinical nurse specialists (CNSs) do. PAs also may reassign their rights to payment for their services and may choose to incorporate as a group comprised solely of practitioners in their specialty and bill the Medicare program, in the same way that NPs and CNSs may do. CMS notes that this amendment only changes the statutory billing construct; it does not change the statutory benefit category or the requirement that PA services are performed under physician supervision.

Billing for Therapy Services

In the CY 2019 PFS final rule, CMS finalized modifiers *-CQ PT services furnished in whole or in part by PTAs* and *-CO OT services furnished in whole or in part by OTAs* to specify therapy services provided in whole or in by Physical Therapy Assistants (PTAs) and Occupational Therapy Assistants OTAs as of January 1, 2020. These modifiers are required to be appended on claims for therapy services, in addition to the already established *-GP* and *-GO* modifiers that indicate the services are furnished under a PT or OT plan of care.

The modifiers apply to physical and occupational therapy services furnished by therapists in independent practice as well as those furnished by CORFs or otherwise paid under the PFS. The modifiers do not apply to therapy services billed by physicians or NPPs because therapy services furnished in physicians' or NPPs' offices must meet the qualifications and standards as if furnished by licensed therapists (although licensure itself is not required).

In the CY 2022 final rule, CMS finalized to revise the *de minimis* policy previously finalized in the CY 2020 PFS final rule which delineate when the *-CQ* and *-CO* modifiers apply. CMS now finalized to allow a timed therapy service to be billed without the *-CQ* and *-CO* modifiers in cases when a PTA or an OTA participates in providing care to a patient with a PT or OT, but the PT or OT meets the Medicare requirements for a timed service without the minutes furnished by the PTA or OTA by providing more than the 15-minute midpoint (also known as the 8-minute rule). Under this proposal, any minutes that the PTA or OTA furnish in the preceding scenario would not matter for purposes of billing Medicare.

II. QUALITY PAYMENT PROGRAM (QPP) PROVISIONS

MIPS Value Pathways (MVPs) and Subgroups

In response to concerns raised by the AMA and the Federation that MIPS is overly burdensome and not clinically relevant, MVPs are intended to hold physicians accountable for cost, quality and use of technology around a condition or episode of care. CMS finalized an initial set of MVPs and detailed scoring and registration policies for individual clinicians, groups, and subgroups interested in participating in this voluntary option beginning in 2023. The finalized seven MVPs include Rheumatology, Stroke Care and Prevention, Heart Disease, Chronic Disease Management, Emergency Medicine, Lower Extremity Joint Repair, and Anesthesia.

The finalized MVP scoring methodology responds to some of the recommendations made to CMS by the AMA after significant consultation with specialty and state medical societies, such as fewer check-the-box reporting requirements. Specifically, CMS finalized to require MVP participants select four, rather than six, quality measures; two medium-weighted or one high-weighted improvement activity; and be scored on only the cost measures included in the MVP. Unfortunately, however, CMS maintains many of the same traditional MIPS reporting and scoring requirements, including requiring reporting on the same Promoting Interoperability measures required under traditional MIPS. Additionally, CMS finalized its proposal to require MVP participants to select one population health measure to be scored on.

CMS finalized its plan to establish a subgroup reporting option for MVP participation by a subset of clinicians in a multispecialty group beginning in the 2026 performance period. To form a subgroup, interested clinicians must identify the MVP the subgroup will report on, identify the clinicians in the subgroup by TIN/NPI, and provide a plain language name for the subgroup for purposes of public reporting. Registration for both MVPs and subgroups would take place between April 1 and Nov. 30 of the performance period. Subgroups would be scored at the subgroup level on Quality, Cost, and Improvement Activities and would receive the group's Promoting Interoperability score.

Quality Performance Category

As required by statute, CMS will reduce the weight of Quality Performance Category from 40 percent to 30 percent of the final MIPS score in for the 2022 performance year. For the 2022 performance period, there are a total of 200 quality measures, which reflect:

- Substantive changes to 87 existing MIPS quality measures (9 of these measures won't be eligible for a historical benchmark due to the extent of changes to the specification);
- Changes to specialty sets;
- Removal of measures from specific specialty sets;
- Removal of 13 quality measures; and
- Addition of 4 quality measures, including 1 new administrative claims measure.

In addition, CMS is extending the CMS Web Interface as a collection type and submission type in traditional MIPS for registered groups, virtual groups and APM Entities with 25 or more clinicians for the 2022 performance year. After analyzing the data, CMS has determined that they will be able to create historical benchmarks for the 2022 performance period, using data submitted for the 2020 performance period. CMS is also maintaining the current data completeness threshold at 70% for the 2022 and 2023 performance periods.

Beginning in PY 2022, with new measures there will be a 7-point scoring floor for the first performance period and a 5-point scoring floor in its second performance period.

Complex Patient Bonus

Because of the concerns of the direct and indirect effects of the COVID-19 PHE, CMS will continue to double the complex patient bonus available for the 2021 MIPS performance year/2023 MIPS payment year. These bonus points (capped at 10-points) would be added to the

final score. CMS also finalized changes to the methodology used to determine eligibility and scoring of the complex patient bonus.

Medicare Shared Savings Program (MSSP)

The CMS Web Interface will be a reporting option for Shared Savings Program ACOs reporting via the APP in performance years 2022, 2023 and 2024. Beginning with the 2025 performance year, Shared Savings Program ACOs will be required to report the 3 electronic clinical quality measures (eCQMs) or MIPS clinical quality measures (MIPS CQMs).

Cost Performance Category

As required by statute, CMS will increase the weight of the Cost Performance Category from 20 to 30 percent of the final MIPS score in 2022 and beyond. CMS will add five new episode-based cost measures, including the first chronic condition cost measures. The finalized measures include Melanoma Resection, Colon and Rectal Resection, Sepsis, Asthma/Chronic Obstructive Pulmonary Disease, and Diabetes. Measure specifications can be downloaded [here](#). CMS also created a new process for stakeholders to develop cost measures for MIPS beginning in 2022 for earliest adoption in MIPS in 2024. Finally, CMS finalized criteria for determining whether a cost measure change is considered substantive and thus must be finalized through notice-and-comment rulemaking before it is implemented in MIPS.

Improvement Activities Category

CMS finalized several new proposals for the Improvement Activities (IA) Performance Category for the 2022 performance year and beyond. Most substantively, it finalized a proposal around group reporting requirements to address subgroup participation. Essentially, each IA for which groups and virtual groups attest to performing must be performed by at least 50 percent of the NPIs that are billing under the group's TIN or virtual group's TINs or that are part of the subgroup, as applicable. The NPIs must perform the same activity during any continuous 90-day period within the same performance year. If, for example, out of a group of 100 Eligible Clinicians, 30 of them choose to form a subgroup, 15 Eligible Clinicians in the subgroup must perform the IA, and 35 (50 percent of the group's remaining 70 Eligible Clinicians) must perform an IA on behalf of the larger group to receive credit. Additionally, CMS revised the timeframe for IAs nominated during a PHE; revised the required criteria for IA nominations received through the Annual Call for Activities; and added seven new IAs, modified 15 existing IAs, and removed six existing IAs. It also finalized a process to suspend IAs that raise possible safety concerns or become obsolete from the program when this occurrence happens outside of the rulemaking process. In response to AMA advocacy, CMS did not finalize a proposal to modify IA_PSPA_6 that would have increased to increase the percentage of applicable patients for whom clinicians must review prescription history within the PDMP from 75 percent to 100 percent; CMS instead finalized an increase to 90 percent and clarified that clinicians should consult CDC prescribing guidelines for determining exceptions to this IA's required prescription history review percentage.

Promoting Interoperability Category

CMS finalized several new requirements and adjustments for the Promoting Interoperability (PI) Category for the 2022 performance year. Most notably, CMS is requiring that physicians report on two public health measures which, prior to the 2022 reporting year, were optional. For the

first new measure, CMS is requiring that physicians must report “yes” to being in active engagement with a public health agency to a) electronically submit case reporting of reportable conditions, and b) submit and receive immunization data. In response to AMA advocacy, CMS has included a new exception for the electronic case reporting (b) measure. In the event physicians do not have an EHR that is certified to the necessary technology to support electronic case reporting, physicians may be exempt from that measure. This exemption is only available for the 2022 reporting year. Additionally, in response to AMA comments, CMS has clarified that “active engagement” with a public health agency only requires the initial outreach by the physician and is not contingent on the physician also receiving a response or invitation from the public health agency. Unless an exclusion can be used for immunization reporting (a) or electronic case reporting (b), physicians who fail to report “yes” on either (a) or (b) would score zero for the PI category.

As an additional new measure, CMS is requiring that physicians conduct an annual self-assessment of the high priority practices listed in [ONC’s SAFER Guides](#). However, in response to AMA comments, CMS has clarified that physicians who attest “no” to this measure (e.g., not conducting the annual self-assessment) will not see an impact to their final MIPS score.

In response to AMA advocacy, CMS is not finalizing its proposal to require that physicians make patient health information available indefinitely starting with encounters on or after January 1, 2016.

CMS is reducing the number of required attestation statements physicians must make related to actions taken that limit or restrict the compatibility or interoperability of their EHRs. CMS finalized its proposal to remove two of the three attestations, simplifying physician compliance with CMS’ information blocking requirement.

For the 2022 reporting year, CMS is not requiring an application from physicians and small practices seeking to qualify for the small practice hardship exception and reweighting. Instead, the exception will be applied automatically. CMS will assign a weight of zero percent to the PI performance category and redistribute its weight to another performance category. In response to AMA comments, CMS states it will coordinate with state/medical societies and other professional organizations to communicate this new automatic application process to physicians in small practices.

Advanced Alternative Payment Model Incentive Payments

CMS finalized its proposed policy to take additional actions to identify changes that may occur in APM participants’ organizational affiliations so that their incentive payments may be paid in a more accurate and timely manner.

The text of the final rule can be accessed at: <https://www.federalregister.gov/public-inspection/current>

Link to the CMS Press Release: <https://www.cms.gov/newsroom/press-releases/cms-physician-payment-rule-promotes-greater-access-telehealth-services-diabetes-prevention-programs>

Link to the Physician Fee Schedule Fact Sheet: <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2022-medicare-physician-fee-schedule-final-rule>

Link to the QPP Fact Sheet and related material: <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1654/2022%20Quality%20Payment%20Program%20Final%20Rule%20Resources.zip>