CY 2022 Medicare Physician Fee Schedule Proposed Rule (CMS-1751-P)

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INTRODUCTORY SUMMARY AND BACKGROUND

On July 13, 2021, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule for the Medicare Physician Fee Schedule (MPFS) for CY 2022.

Since 1992, Medicare has paid for physician services under section 1848 of the Social Security Act entitled "Payment for Physicians' Services". This statute requires CMS to establish payments under the physician fee schedule (PFS) based on national uniform relative value units (RVUs) that account for the relative resources used in furnishing a service.

The statute requires that RVUs be established for three categories of resources:

- Work **(Work)** – services the physician provides.
- Practice Expense **(PE)** – resources that are used to provide physician services, such as office overhead and staff salaries.
- Malpractice **(MP)** expense – costs involved in malpractice insurance.

In addition, the statute requires CMS establish by regulation each year's payment amounts for all physicians' services paid under the PFS, incorporating geographic adjustments to reflect the variations in the costs of furnishing services in different geographic areas. This is referred to as the geographic practice cost indices **(GPCIs)**.

RVUs are converted to dollar amounts through the application of the conversion factor **(CF)**. The formula for the calculating the MPFS is as follows:

Payment = [(RVU work x GPCI work) + (RVU PE x GPCI PE) + (RVU MP x GPCI MP)] x CF

MPFS Proposed Rule

The CY 2022 proposed rule is located in its entirety at the following link:
https://www.federalregister.gov/public-inspection/2021-14973/medicare-program-cy-2022-payment-policies-under-the-physician-fee-schedule-and-other-changes-to-part

This document in PDF form is 1,747 pages in length. The format of the information is intended to summarize the proposed changes so readers are encouraged to view the document in its entirety for further details.

PROPOSED CHANGES TO MPFS PAYMENT RATES

Conversion Factor (CF)

Section 1848 of the Act requires CMS to maintain the budget within $20 million annually. In the event it is projected to exceed this amount, budget neutrality adjustments are made. In the CY 2022 proposed rule, CMS

is reversing the 3.75 percent increase outlined as part of the Consolidated Appropriations Act of 2021, which reversed the 10.2 percent cut finalized to the conversion factor (CF) for CY 2022. Removing this and utilizing a CF of 33.6319, CMS applied a budget neutrality factor of -0.14 percent. This results in a proposed CF of $33.5848, which is a reflection of the factors seen in the table below:

TABLE 121: Calculation of the CY 2022 PFS Conversion Factor

CY 2021 Conversion Factor		34.8931
Conversion Factor without CY 2021 Consolidated Appropriations Act Provision		33.6319
Statutory Update Factor	0.00 percent (1.0000)	
CY 2022 RVU Budget Neutrality Adjustment	-0.14 percent (0.9986)	
CY 2022 Conversion Factor		**33.5848**

Changes in RVUs

Significant RVU changes are not proposed to impact all specialties equally. Impacts to the RVUs are related to changes associated to RVUs for specific services resulting from the misvalued code initiative, including RVUs for new and revised codes. Some specialties reflect increases when compared to other physician specialties. This is largely due to the proposed update to clinical labor pricing, since their services generally rely on clinical labor for their Practice Expense (PE) costs. These increases are also due to proposed increases in value for specific services based on recommendations from the American Medical Association (AMA)'s Relative Value Scale Update Committee (RUC); CMS review; and increased payments resulting from updates to supply and equipment pricing.

Table 123 outlines the combined payment impact per specialties including cardiac surgery, interventional radiology and vascular surgery pertaining to the proposed RUV changes for CY 2022:

TABLE 123: CY 2022 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F)* Combined Impact
Cardiac Surgery	$203	0%	-1%	0%	-1%
Interventional Radiology	$480	0%	-9%	0%	-9%
Vascular Surgery	$1,144	0%	-8%	0%	-8%

* Column F may not equal the sum of columns C, D, and E due to rounding.

The decrease in CF does result in decrease in many specialties and their proposed impact; however, CMS has also applied additional decreases to many of the Practice Expense (PE) values which reflect a deeper cut to specialties such as interventional radiology, radiation oncology, vascular surgery, and oral/maxillofacial surgery. These specialty services involve PE costs that rely on supply or equipment items, which are negatively impacted by the proposed updates to clinical labor pricing. Most of the resulting cuts for the impacted specialties are due to labor pricing transition values.

Work RVUs

Work RVUs are established for new, revised and potentially misvalued codes based on portion of resources used in furnishing the service that reflects physician time and intensity. CMS conducts a review that includes the current work RVU; RUC-recommended work RVU; intensity; time to furnish the preservice, intraservice, and postservice activities; and other components of the service that contribute to the value. For particular codes, CMS refines the work RVUs in direct proportion to the changes in the best information regarding the time resources involved to furnish particular services, either considering the total time of the intraservice time. Common refinements include:

- Changes in work time
- Equipment time
- Standard tasks and minutes for clinical labor tasks
- Recommended items that are not direct PE inputs
- New supply and equipment items
- Service period clinical labor time in the facility setting
- Procedures subject to the multiple procedure payment reductions (MPPR) and OPPS cap

For CY 2022, CMS has identified over 100 new, revised and potentially misvalued code categories for proposed valuation. Stakeholders have expressed concerns regarding the additional costs for physicians and NPPS due to the COVID-19 PHE, such as personal protective equipment and increased time spent with patients to rule out a COVID-19 infection or treat a confirmed COVID-19 infection. CMS states their payment systems including PFS are not typically designed to accommodate more acute increases in resource costs, even if they are widespread. However, they acknowledge these circumstances, and have developed and implemented polices to maintain beneficiary access to necessary services during the PHE.

CMS continues to consider the types of resource costs that may not be fully reflected in payments for existing services, or costs that could be included by establishing new payments rate for new services. CMS is interested in feedback from stakeholders regarding additional strategies to account for PHE-related costs, including infectious disease control measures, research-related activities; or services or PHE-related preventative or therapeutic counseling services.

Practice Expense RVUs (PE)

PE RVUs are developed by reviewing practice resources involved in providing each service and are comprised of direct and indirect PE. For direct PE (clinical staff, medical supplies, medical equipment), these costs are calculated based on inputs from the CMS PE database, generally centered on recommendations of the Relative Value Scale Update Committee (RUC). Indirect PE costs are developed primarily on the Physician Practice Expense Information Survey (PPIS). Implemented in CY 2010, the PPIS is a multispecialty, nationally representative, PE survey of both physicians and NPPs paid under the PFS.

For procedures provided in a physician's office or facility setting in which Medicare makes a separate payment to the facility, CMS establishes 2 PE RVUs: facility and nonfacility. In calculating PE RUVs for physician services provided in a facility, resources not typically utilized by physicians while providing services are excluded. Thus, facility PE RVUs are typically lower than nonfacility PE RUVs.

Diagnostic services are generally comprised of a professional component (PC); and a technical component (TC). The PC and TC may be furnished independently, by different providers, or together as a global service. Each

component has separate reimbursement; however, payment for the global service equals the sum of the payment for TC and PC. This is based on a weighted average of the ratio of direct to indirect costs across all specialties that provide the global service.

Payment modifiers are included in the creation of the PE MP RUV utilization files. These modifiers reflect current payment policy as implemented in claims processing. For example, services billed with the assistant at surgery modifiers are paid at 16 percent for a PFS service in which an assistant surgeon is allowed and has the assistant at surgery modifier appended to the code. This means the utilization file is modified to allow for 16 percent of the service that contains the assistant at surgery modifier. Table 2 below details how the modifiers are applied:

TABLE 2: Application of Payment Modifiers to Utilization Files

Modifier	Description	Volume Adjustment	Time Adjustment
80,81,82	Assistant at Surgery	16%	Intraoperative portion
AS	Assistant at Surgery – Physician Assistant	14% (85% * 16%)	Intraoperative portion
50 or LT and RT	Bilateral Surgery	150%	150% of work time
51	Multiple Procedure	50%	Intraoperative portion
52	Reduced Services	50%	50%
53	Discontinued Procedure	50%	50%
54	Intraoperative Care only	Preoperative + Intraoperative Percentages on the payment files used by Medicare contractors to process Medicare claims	Preoperative + Intraoperative portion
55	Postoperative Care only	Postoperative Percentage on the payment files used by Medicare contractors to process Medicare claims	Postoperative portion
62	Co-surgeons	62.5%	50%
66	Team Surgeons	33%	33%
CO, CQ	Physical and Occupational Therapy Assistant Services	88%	88%

Malpractice RVUs (MP)

MP RVUs are considered to be resourced based, and required to be reviewed annually to more accurately represent and evaluate mix of practitioners providing services on Medicare claims. There are three factors which are considered to determine MP RVUs for PFS services:

1) Specialty-level risk factors derived from data on specialty-specific MP premiums incurred by practitioners;
2) Service-level risk factors derived from Medicare claims data of the weighted average risk factors of the specialties that furnish each service; and
3) Intensity/complexity of service adjustment to the service level risk factor based on either the higher of the work RVU or clinical labor RVU.

Prior to CY 2016, MP RVUs were updated every 5 years unless there were new or revised codes introduced. MP GPCI is currently reviewed every three years. The CY 2016 MPFS final rule implemented the policy to review MP RVUs annually. The new policy also specifies use of 3 years' worth of data rather than 1 year.

For CY 2020, CMS finalized their proposal that the values of the MP RVUs and MP GPCI be coordinated because the MP premium data used to update the MP GPCI is the same to determine the risk levels of the specialties.

This change would put the next review for implementation in CY 2023. Therefore, there are no proposed changes for CY 2022.

Geographic Practice Cost Indices (GPCIs)
CMS is required to develop separate GPCIs to measure cost differences among localities compared to the national average. CMS adjusts reimbursement to align with the cost of those services specific to where they were provided. This is done by applying the GPCI values for a specific area to each of the RVUs (work, practice expense, and malpractice). This is one of the reasons when discussing reimbursement, it is not always an apples-to-apples comparison with regard to how much is reimbursed from one location to another.

The current fee schedule areas are referred to as payment localities are defined by state boundaries; metropolitan areas; portions of a metropolitan area; or rest-of state areas. There are currently 112 payment localities. This locality configuration is used to calculate GPCIs that in turn are used to calculate locality adjusted payment for physicians under PFS.

Five states are defined as "frontier states" by CMS: Montana, Wyoming, North Dakota, South Dakota and Nevada. A frontier state is one in which at least 50 percent of the counties are "frontier counties" (counties that have a population per square mile of less than 6). This is significant because the cost of living can be relative to how populated an area might be. Thus, a less populated area could have less services and lower reimbursement. These frontier states have a PE GPCI floor of 1.000, effective CY 2011.

For CY 2022, there are no proposed updates for GPCIs. CMS refers to updates for CY 2020 as the latest updates for GPCIs.

Evaluation and Management (E/M) Changes

CMS indicated when the American Medical Association (AMA) adopted the new guidelines for outpatient and office setting E/M visits, CMS also adopted the changes. In the months since implementation, CMS indicated there was a need for clarification or adjustment to previous guidelines to align all guidance more fully with the updates. To do the CMS specifically addressed a few areas:

- Split (or Shared) Visits
- New and Established Patients, and Initial and Subsequent Visits
- Payment for the Services of Teaching Physicians

Split (or Shared) Visits
CMS indicated the guidelines do not address who to bill the visit under when performed by different practitioners, whether a substantive portion must be performed by the billing practitioner, whether practitioners must be in same group, or the setting where the split (or shred) visits may be furnished to be billed.

The AMA within the 2021 CPT® E/M Guidelines states, "A split or shared visit is defined as a visit in which a physician and other qualified health care professional(s) jointly provide the face-to-face and non-face-to-face work related to the visit. When time is being used to select the appropriate level of services for which time-based reporting of shared or split visits is allowed, the time personally spent by the physicians and other qualified health care professional(s) assessing and managing the patient on the date of the encounter is summed to define total time. Only distinct time should be summed for split or shared visits (that is, when two or more individuals jointly meet with or discuss the patient, only the time of one individual should be counted)."

CMS is proposing to define a split (or shared) visit as an E/M visit performed (split or shared) by both a physician and nonphysician practitioner (NPP) who are in the same group in accordance with applicable laws and regulations. The visit is provided in a facility setting in which payment for services furnished incident to is prohibited. In the nonfacility setting, when the physician and NPP each perform components of the visit, it can be billed under the physician if the incident-to criteria are met. The services are provided in accordance with applicable laws and regulations, specifically either the physician or NPP could bill the payer directly for the visit in the facility setting, rather than bill as a split (or shared) visit. CMS is also proposing to allow for split (or shared) visits to be billed for both new and established E/M patient visits.

CMS is also clarifying the only the physician or NPP who performs the substantive portion of the split (or shred) visit) bills for the visit. CMS is defining "substantive portion" to mean more than half of the total time spent by the physician or NPP performing the visit. Due to the need to determine the amount of time spent by each entity, CMS is recommending documentation of the time is included in the note, even if medical decision making (MDM) method is selected to code the visit. In addition, the entity who performs the substantive portion of the visit is the one to sign and date the note, but documentation should include the names and credentials of both entities.

CMS is also proposing the total time between the physician and NPP are totaled, and the one with the more than half time will bill the visit based on total time documented. CMS has also proposed the prolonged services could be billed in addition to the visit when time-based method is used with the total time between the two entities used for billing.

CMS has also proposed a list of services which would count toward the total time for determining the substantive portion. Activities include preparing to see the patient (for example, review of tests), obtaining and/or reviewing separately obtained history, performing a medically appropriate examination and/or evaluation, counseling and educating the patient/family/caregiver, ordering medications, tests, or procedures, referring and communicating with other health care professionals (when not separately reported), documenting clinical information in the electronic or other health record, independently interpreting results (not separately reported) and communicating results to the patient/ family/caregiver, care coordination (not separately reported).

CMS also outlines items that would not count toward time spent in the visit performance of other services that are reported separately, travel or teaching that is general and not limited to discussion that is required for the management of a specific patient.

CMS is also proposing to create a modifier for billing purposes to identify the visit as a split (or shared) visit. This will allow Medicare to collect data on the frequency and quality of visits provided in part by NPPs but paid to physicians for the full rate.

If the physician and NPP are not in the same group, they would each be expected to bill independently based on the full E/M criteria for the work provided. If neither of them meets the criteria to bill a visit, modifier 52 for reduced services cannot be applied to the E/M visit codes. In this scenario, no visit would be billable by either entity.

Payment for the Services of Teaching Physicians

Stakeholders have requested guidance on how time spent by the resident should be counted when selecting the appropriate E/M office visit level. Section 1842(b) of the Act specifies "in the case of physicians' services furnished to a patient in a hospital with a teaching program, the Secretary shall not provide payment for such

services unless the physician renders sufficient personal and identifiable physicians' services to the patient to exercise full, personal control over the management of the portion of the case for which payment is sought. Regulations regarding PFS payment for teaching physician services".

CMS is proposing when total time is used to determine the appropriate E/M office visit level, only the time the teaching physician was present can be included. Medicare already makes payment for the program's share of the resident's involvement, due to this CMS does not feel it would be appropriate to count the resident time toward the total time, only that of the teaching physician would count.

Telehealth Services

CMS received several requests from stakeholders to permanently add several services to the Medicare telehealth services list effective for CY 2022. None of the requests received by the February 10th deadline met the criteria for Category 1 or Category 2 criteria to be added permanently.

In response to the COVID-19 PHE, the CY 2021 PFS final rule CMS created a third category of criteria for adding services to the Medicare telehealth list on a temporary basis. The services added to this category are considered to be a clinical benefit when furnished via telehealth; however, there is not sufficient evidence available to consider the services as permanent additions under Category 1 or Category 2 criteria. CMS acknowledges the services under Category 3 would ultimately need to meet criteria under Categories 1 and 2 in order to be permanently added to the Medicare telehealth services list. CMS is proposing to keep all services added to the Medicare telehealth services under Category 3 until the end of 2023. This would allow more time for data collection regarding utilization; and submission of requests to add services permanently to the Medicare telehealth services list for consideration in the CY 2023 rulemaking process and CY 2024 PFS rule.

There are a series of codes which CMS has only added to the list of telehealth services for the duration of the PHE: however, they have not been given temporary Category 3 status. These services will be removed from telehealth when the PHE ends. As of July 20, 2021, the PHE has been extended for another 90 days. CMS is soliciting comments whether any of the following services added for the duration of the PHE should be added to the Medicare telehealth list on a Category 3 basis to allow for collection of data to consider permanent addition to the list:

- Hospital Inpatient Services: 99221-99223
- Office/Outpatient Services: 99441-99443 (no payment would be made for these services when furnished using interactive telecommunications system after the end of the COVID-19 PHE)
- Observation Care Services: 99218-99236
- Critical care services: 99468, 99471, 99473, 99475, 99477

Communication Technology-Based Services

CMS did address the audio only visit codes (CPT® 99441-99443). These are expected to be removed from the list of approved telehealth services as indicated above. However, CMS is proposing to revise the 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 in their home. This includes interactive, real-time and two-way audio-only technology. CMS would identify the patient's home as an originating site for telehealth services for mental health disorders, effective for services provided on or after the Friday after the end of the PHE. The following conditions would apply:

- The distant site provider has the technical capability at the time of the service to use video; and
- The patient is not capable of or does not consent to the use of video for the service.

With this proposal, CMS states there would need to be an in-person visit within 6 months of any telehealth services furnished for the diagnosis, evaluation or treatment of mental health disorders other than substance use disorder or co-occurring mental health disorder. The in-person visit documentation in the patient's medical record would be required, and payment would not be made unless the in-patient visit was furnished within 6 months of the telehealth service.

CMS is proposing to permanently adopt coding and payment for HCPCS code G2252, one of the communication-based services recognized by CMS billable by physician or qualified healthcare professional (QHP) for a brief check-in lasting 11-20 minutes. Originally this service was created to be used on an interim basis. After stakeholder feedback of the need for a communication service longer than 10 minutes, CMS is now proposing to make code G2252 permanent with an assigned payment:

Code	Description
G2252	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion)

Physician Supervision of Therapeutic Services

For the duration of the PHE, CMS redefined direct supervision under PFS to be provided through interactive real-time audio-video telecommunication technology. This allows the physician to provide real-time assistance and direction throughout a procedure or service by allowing them to see and interact with the staff member and patient without adding any unnecessary exposure. It is important to note, the supervision adjustments are meant as a minimum requirement. There may be circumstances in which the physical presence of the physician with the patient in the same location is necessary and more appropriate, for example administration of certain drugs or therapies. CMS stressed in these types of scenarios the physician and facility must make the best decision given the situation, even if this means potential exposure due to the nature of the scenario.

For CY 2022, CMS is seeking feedback on the flexibilities extended during PHE related to physician supervision, specifically whether additional time is needed beyond the conclusion of the PHE before returning to the standard application of direct supervision.

Outside of the PHE, direct supervision in the office setting is the requirement. This "requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service, and we have interpreted this "immediate availability." Under the waivers and extensions during the PHE, CMS continued the requirement of direct supervision, but allowed this to be performed through the use of real time audio/video capabilities.

CMS is also seeking comments whether direct supervision in the office setting should be permanently allowed by real time audio/video capabilities for only a subset of services; and whether a service level modifier should be created to identify when the requirements for direct supervision were met using real time audio/video capability, if it were extended.

Physician Supervision of Physician Assistant (PA) Services

Currently Physician Assistants (PAs) cannot bill independently for their services. In addition, all payments are made to the PAs employer, not directly to the PA. Under section 403 of the Consolidated Appropriations Act, 2021 (CAA), CMS has proposed to allow for PAs to bill for services directly to Medicare and the reimbursement for those services to be paid directly to the PA, similar to Nurse Practitioners (NPs) and Clinical Nurse Specialists (CNSs) currently effective January 1, 2022. This includes professional services as well as supplies furnished incident to their services. PAs would be allowed to reassign their rights to payments for their services and may choose to incorporate as a group solely comprised of practitioners in their specialty billing in the same manner as NPs and CNSs.

Submitting Comments

Comments to CMS regarding the MPFS proposed rule must refer to file code **CMS-1751-P** and must be received **no later than 5 pm EST September 13, 2021**. Electronic and mail submissions are acceptable, electronic submissions are encouraged: http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.