Summary of 2022 Changes to the Medicare Physician Fee Schedule, Quality Payment Program, and Other Federal Programs

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represents a change from current CMS policy, which requires a single clinician or NPP to perform the initial 30-74 minutes of critical care services each day.

- Critical care services can be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty, regardless of their group.
- Critical care services can be furnished as split (or shared) visits. The list of activities that can count toward total time spent for purposes of determining the substantive portion for split visits will incorporate the activities in CPT codes 99291 and 99292.
- CMS rejects the CPT rule that critical care and other E/M visits may be furnished to the same patient on the same date by the same clinician and would not allow other E/M visits to be billed for the same patient on the same date as a critical care service when the services are furnished by the same practitioners, or by practitioners in the same specialty and same group to account for overlapping resource costs. CMS is requesting comments on whether this is the right approach.
- Critical care visits cannot be reported during the same time period as a procedure with a global surgical period.

Teaching Physician Services and Primary Care Exception Flexibilities

Following the 2021 changes to coding for office/outpatient E/M visits that permit the clinician to select the visit level based either on medical decision making (MDM) or total time, questions were raised about how teaching physicians who involve residents in furnishing care should consider time spent by the resident in selecting the appropriate E/M level. Currently, if a resident participates in a service furnished in a teaching setting, a teaching physician can bill for the service only if they are present for the key or critical portion of the visit. However, under š Z ^ ‰ Œ] u Œ Ç Œ Æ ‰ š] } v _ š } š Z] • ‰ } o] Ç U š Z š Z] v P ‰ hospital primary care centers for certain services furnished by a resident without the physical presence of a teaching physician.

In the Proposed Rule, CMS proposes that the time when the teaching physician was present can be included when determining the E/M visit level. However, for services furnished pursuant to the primary care exception, only MDM can be used to select the E/M visit level. CMS is seeking feedback on its assumption that MDM is a more accurate indicator of the appropriate level of the visit relative to time in the context of the primary care exception for services furnished by residents and billed by teaching physicians in primary care centers. CMS is also seeking comments on whether time is an accurate indicator of the complexity of the visit and how teaching physicians might select an office/outpatient E/M visit level using time when directing the care of a patient that is being furnished by a resident in the context of the primary care exception. After expiration of the PHE, office/outpatient levels 1-4 will no longer be included in the primary care exception.

Valuation of Specific Codes

For CY22, the RVS Update Committee (RUC) surveyed the Chronic Care Management (CCM) code family, including Complex Chronic Care Management (CCCM) and Principal Care Management (PCM), and added five new CPT codes.

The CCM/CCCM/PCM code family now includes five sets of codes, each set with a base code and an add-on code. The sets vary by the degree of complexity of care (CCM, CCCM, or PCM), who furnishes the care (clinical staff or the physician or NPP), and the time allocated for the services.

CMS reviewed the RUC-recommended values for the 10 codes in the CCM family and is proposing to accept the recommended work values for the codes. CMS <(es.)] TJ ET Q 3 n BT /F1 T /nC

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	97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes
Personal Care	98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient
	98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients
	98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients

		hospital "observation status" are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	
	99220	Initial observation care, per day, for the evaluation and management of a patient which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission to outpatient or hospital "observation status" are of high severity. Typically, 70 minutes are spent at the bedside and on the patient's hospital floor or unit.	
	99234	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of low severity. Typically, 40 minutes are spent at the bedside and on the patient's hospital floor or unit.	2
	99235	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of moderate severity. Typically, 50 minutes are spent at the bedside and on the patient's hospital floor or unit.	2
	99236	Observation or inpatient hospital care, for the evaluation and management of a patient including admission and discharge on the same date, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually the presenting problem(s) requiring admission are of high severity. Typically, 55 minutes are spent at the bedside and on the patient's hospital floor or unit.	2
Nursing Facility Services	99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, o	2

		agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.	
	99305	Initial nursing facility care, per day, for the evaluation and management of a patient,	

		Typically, 45 minutes are spent with the patient and/or family or caregiver.	
	99237	Domiciliary or rest home visit for the evaluation and manageme of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent wit the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity. Typically, 60 minutes are spent with the patient and/or family or caregiver.	2
	99238	Domiciliary or rest home visit for the evaluation and manageme of a new patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant new problem requiring immediate physician attention. Typically, 75 minutes are spent with the patient and/or family or caregiver.	2
	G9685	Physician service or other qualified health care professional for th evaluation and management of a beneficiary's acute change in condition in a nursing facility. This service is for a demonstration project	2
Home Services	99341	Home visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low severity. Typically, 20 minutes are spent face-to-face with the patient and/or family.	2
	99342	Home visit for the evaluation and management of a new patient which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, 30 minutes are spent face-to-face with the patient and/or family.	2
	99343	Home visit for the evaluation and management of a new patient which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencie are provided consistent with the nature of the problem(s) and the patient's and/or family's needs.	2

New Originating Site

The CAA (2021) included a number of provisions pertaining to Medicare telehealth services. The Medicare telehealth statute at Section 1834(m)(4)(C) of the Act generally limits the scope of [illegible] As required by Section 123(a) of the CAA (amending section 1834(m)(4)(C)(i) of the Act), CMS is broadening the scope of services for [illegible] permissible originating site to include telehealth services furnished for the purpose of diagnosis, evaluation, or treatment of a mental health disorder, effective for services furnished on or after the end of the PHE. CMS is additionally proposing to amend its regulations to conform with the statutory change of the CAA to include rural emergency hospitals as telehealth originating sites beginning in CY23.

Section 123(a) of the CAA also added a prohibition on payment for a telehealth service [illegible] in-person, without the use of telehealth, within six months prior to the first time the clinician or practitioner furnishes a mental health telehealth service to the beneficiary. This requirement shall not apply to telehealth services furnished for treatment of a diagnosed substance use disorder (SUD) or co-occurring mental health disorder, or to services furnished in an originating site or that meet the geographic requirements specified. In order to implement the new requirement, CMS is proposing that, as a condition of payment, the billing clinician or practitioner must have furnished an in-person, non-telehealth service to the beneficiary within the six-month period before the date of the mental health telehealth service. The Agency is also proposing that this distinction between the telehealth and non-telehealth services must be [illegible] CMS is seeking comment on whether the required in-person, non-telehealth service could also be furnished by another clinician or practitioner of the same specialty and same subspecialty within the same group as the clinician or practitioner who furnishes the telehealth service. CMS is also seeking comment on whether it would be appropriate to establish a different interval (other than the proposed six months) for these telehealth services when furnished as permitted using audio-only communications technology.

CMS reiterates its longstanding concerns over program integrity and quality of care, but the Agency believes a reassessment of these concerns is reasonable given the now widespread utilization during the PHE of audio-only telehealth services. Based upon an initial review of audio-only

- Requiring a service level modifier, if this flexibility were made permanent, to identify when the requirements for direct supervision w

CMS recently made several changes to the Stark Law regulations, which were effective January 19, 2021. Among the changes finalized, the Agency revised š Z ( ] v] š] } v } (^] v] Œ š } u ‰ v • š] } v Œ Œ which added a second condition related to the compensation under review for the compensation to potentially implicate the Stark Law. In the CY22 Proposed Rule, CMS is backtracking its definition. Specifically, CMS is revising the definition to make clear it only applies if the compensation arrangement closest to the clinician's directly } u ‰ v • š] } v (} Œ š Z š o] v]] v [• ~ } Œ o] v]] personally performed services. All other arrangements would be analyzed under essentially the same definition that was in effect prior to January 19, 2021.

CMS is also pr ‰ } •] v P š } ( ] v µ š Z] š Á ^ } Œ v š ^] v] v š Z ( ] v] š] } v } (^] v] Œ } u ‰ v • š] } v Œ Œ v P u v š _ Á Z] Z Á • ( ] v o] Ì] v : v µ Œ Ç î ì î í X h ^ µ v] š _ Á } µ o ( ] v • W ~ í • š] u U Á Z Œ š Z } u ‰ v • š] } v ‰] immediate family member) is based solely on the period of time during which the services are provided; (2) service, where the compensation paid to the clinician (or immediate family member) is based solely on the service provided; or (3) time, where the compensation paid to the physician (or immediate family member) is not based solely on the period of time during which a service is provided or based solely on the service provided.

In connection with the PHE for the COVID-19 pandemic, CMS is additionally proposing revisions to the Stark exception for Preventive Screening Tests, Immunizations, and Vaccines at 42 CFR § 411.355(h). CMS states these changes are to ensure that the way the exception currently reads does not impede the availability of COVID-19 vaccines for Medicare and other patients. The exception currently only excepts referrals for vaccines that are subject to mandated (Œ ‹ µ v Ç o] u] š • X / ( ] v o] Ì U š Z W Œ } ‰ } • Z µ o Á } µ o u l ‰ availability for the COVID-19 vaccine even if CMS does not impose the frequency limits for the vaccine.

Updates to the Open Payments Program

The Open Payment program is a statutorily mandated program that promotes transparency by providing information to the public about financial relationships between the pharmaceutical and medical device industry, and clinicians. In the Proposed Rule, CMS proposes changes related to the collection of Open Payments data beginning in 2023 for reporting in 2024. These changes include:

- Adding a mandatory payment context field for payments or transfers of value attributed to teaching hospitals;
- Adding the option to recertify annually even when no records are being reported;
- Disallowing record deletions without substantiated reason;
- Updating the definition of ownership and investment interest;
- Adding a definition for a clinician-owned distributorship as a subset of applicable manufacturer and group purchasing organizations;

- Requiring reporting entities to disclose relationships they have with other companies for the purposes of transparent reporting;
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CMS further proposes that, in order for prescribers to be considered compliant, they must prescribe at least 70 percent of their Part D controlled substances (Schedule II, III, IV, and V) prescriptions electronically per calendar year. Proposed exceptions to this requirement would be for prescriptions issued where the prescriber and dispensing pharmacy are the same entity, prescribers who prescribe 100 or fewer Part D controlled substance prescriptions per year, prescribers who are prescribing during a recognized emergency (e.g., a natural disaster or pandemic), and prescribers who request and receive a waiver from CMS due to extraordinary circumstances. As a means of enforcement, CMS proposes that its compliance actions in CY 2023 would consist of sending letters to prescribers that the Agency believes are violating the EPCS requirement. The Agency notes it will consider whether further compliance actions will be necessary in future rulemaking and is requesting feedback on this method and the proposed threshold.

The Agency requests comments on whether there are any concerns that should be addressed regarding the way the EPCS program is working. CMS is also seeking comment on whether there are any concerns about the cost of implementing and using EPCS.

Appropriate Use Criteria (AUC) Program for Advanced Diagnostic Imaging

The Protecting Access to Medicare Act of 2014, Section 218(b), established the Appropriate Use Criteria program. In the CY 2018 PFS Final Rule, CMS stated January 1, 2020, as the effective date for the program, with the first year serving as the operations and education testing period. In response to the COVID-19 pandemic, in July 2020, CMS extended the testing period an additional year. Under this program, there are two sets of HCPCS modifiers. The first set is to be included on the same claim line as the order. This set identifies the Clinical Decision Support Mechanism (CDSM) consults and reports whether the imaging ordered adheres to the AUC, or if the CDSM does not contain applicable AUC. The second set of modifiers is available for use when the ordering professional does not consult a qualified CDSM.

In the CY22 Proposed Rule, CMS proposes to delay the effective date for the penalty period until January 1, 2023, or January of the year following the end of the PHE, whichever is later. CMS believes this delayed implementation is a proper acknowledgment of the impact of the COVID-19 pandemic and the time required to implement any operational changes to its claim processing and prepare for the upcoming penalty phase.

CMS is seeking comment on whether it is more appropriate to deny or return claims that fail AUC claims processing edits during this period. Specifically, CMS is considering whether claims that do not pass the AUC claims processing edits, and therefore will not be paid, should be initially returned to the health care clinician so they can be corrected and resubmitted, or should be denied so they can be appealed. CMS also requests comment on whether the penalty phase should begin first with returning claims and then transition to denying claims after a period of time. The Agency hopes this feedback will help it better understand which pathway would be most appropriate once the AUC program is fully implemented.

- x Q398: Optimal Asthma Control
- x Q438: Statin Therapy for the Prevention and Treatment of Cardiovascular Disease
- x Q047: Advanced Care Plan
- x TBD: Person-Centered Primary Care Measure Patient Reported Outcome Performance Measure

Improvement Activities

- x IA_BE_4: Engagement of patients through implementation of improvements in patient portal
- x IA_BE_21: Improved practices that disseminate appropriate self-management materials
- x IA_CC_13: Practice improvements for bilateral exchange of patient information
- x IA_AHE_3: Promote use of Patient-Reported Outcome Tools
- x IA_BE_20: Implementation of condition-specific chronic disease self-management support programs
- x IA_BE_22: Improved practices that engage patients via virtual visit
- x IA_CC_2: Implementation of improvements that contribute to more timely commuprovemanagement

not be eligible for a bonus or potentially face a penalty based on their MIPS performance in 2021.

PY22 Scoring and PY21 Performance Feedback

CMS is proposing to sunset traditional MIPS at the end of the 2027 performance and data submission periods and move to using only MVPs. The Agency notes that MIPS has been criticized as being expensive and time consuming, with low positive payment adjustments as a reward, and an uncertainty regarding its impact on patient care. At the same time, however, CMS raises concern about the proposal to sunset traditional MIPS because MVPs remain untested, and it is unclear whether there will be MVP options for all participants.

CMS is statutorily required to weight the cost and quality performance categories equally beginning with PY22. For PY22, the proposed MIPS performance category weights are summarized below (compared to PY 2021):

Performance Category	PY 2021 Weight	PY 2022 Proposed Weight	Percent Change

1. Relevance to an existing MIPS subcategory (or a proposed new subcategory).
2. Importance of an activity toward achieving improved beneficiary health outcomes.
3. Feasible to implement, recognizing importance in minimizing burden, including, to the extent possible, for small practices, practices in rural areas, or in areas designated as geographic Health Professional Shortage Areas by the Health Resources and Services Administration (HRSA)
4. Evidence supports that an activity has a high probability of contributing to improved beneficiary health outcomes.
5. Can be linked to existing and related MIPS quality, promoting interoperability, and cost measures, as applicable and feasible.
6. CMS is able to validate the activity.

Finally, the Agency is proposing six optional factors that they may use to consider nominated activities (made up of previously finalized criteria):

1. Alignment with patient-centered medical homes.
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3. Responds to a PHE as determined by the Secretary.
4. Addresses improvements in practice to reduce health care disparities.
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6. Representative of activities that multiple individual MIPS eligible clinicians or groups could perform (i.e., primary care, specialty care).

Cost Category

CMS is proposing to add five newly developed episode-based cost measures into the MIPS cost performance category beginning with the CY 2022 performance period.

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Quality ID#: 370	Depression Remission at Twelve Months	CMS Web Interface*	APM Entity/Third Party Intermediary	Treatment of Mental Health

+ Note that Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (Quality ID# 438); Depression Remission at Twelve Months (Quality ID# 370), and Preventive Care and Screening: Screening for Depression and Follow-up Plan (Quality ID# 134) do not have

- In PY 2024, the threshold for the quality performance standard will increase to the 40th percentile MIPS Quality performance category score.
- Finally, for PY 2021 and subsequent performance years, we clarify that CAHPS for MIPS minimum sampling thresholds also apply to Shared Savings Program ACOs

Medicare Diabetes Prevention Program (MDPP)

The MDPP was developed to prevent Medicare enrollees with prediabetes from converting into full diabetes. Participating entities give structured, coached sessions using CDC Centers for Disease Control and Prevention (CDC) curriculum to provide training related to diet, exercise, and weight management. During the PHE, CMS waived the fee to participate, resulting in an increase in participation.

Following expiration of the PHE, CMS is proposing to continue the waiver of the enrollment application fee beginning on January 1, 2022. CMS is additionally proposing to increase the performance payments when patients achieve a five percent weight loss goal, as well as proposing changes to beneficiary eligibility after January 1, 2022. These changes are intended to minimize barriers to participation and enhance the program.

Advancing to Digital Quality Measurement and the Use of FHIR® in Physician Quality Programs: Request for Information

The Proposed Rule includes a RFI to collect information on planning and transitioning CMS programs to complete digital measurement by 2025. Maintaining alignment with the Department of Health and Human Services (HHS) Health Quality Roadmap, CMS is approaching priorities and initiatives with other entities, like the ONC (i.e., 21st Century Cures Act) to promote data interoperability and access. The RFI seeks comments on the following:

- CMS adoption of FHIR® to reduce the collection and analysis burden imposed by current electronic quality measures. Under the HL7 framework, quality data reporting programs would utilize a standardized data collection structure and single terminology to collect electronic measure data.
- Enhancement of the definition of dQM so that it contains language regarding proposed software that processes digital data to determine measure scores.
- Z •] P v ‹ µ o] š Ç u • µ } Œ š •] v • ^ š } (• _ š Z š Y D • } (š Á Œ] v } Œ end-to-end measure calculation solutions.
- Alignment of quality measure reporting programs across federal and state agencies and other sectors via the adoption of a dQM portfolio.

Health Equity Initiative: Request for Information

CMS makes several propos • š } À v Z o š Z ‹ µ] š Ç U } v •] • š v š Á] š Z W Œ recent Executive Order 13985. The 2022 Proposed Rule includes a RFI asking for feedback on š Z P v Ç [• ((} Œ š • š } } o o š] š] } v o š š }] v š] (Ç v Œ • %