



CY 2022 Medicare Physician Fee Schedule Final Rule

Major Provisions

On November 2, the Centers for Medicare and Medicaid Services (CMS) released the final rule for the 2022 Medicare Physician Fee Schedule (MPFS): <https://public-inspection.federalregister.gov/2021-23972.pdf>.

This document provides ASH members with a summary of the major provisions for the MPFS final rule impacting hematologists/oncologists, including charts showing physician work relative value units and national average Medicare payment rates for hematology/oncology and evaluation and management (E/M) services.

Conversion Factor

CMS finalized a conversion factor (CF) for 2022 of \$33.5983. The decrease from the 2021 CF (\$34.89) is in part due to the expiration of the 3.75 percent increase for services furnished in 2021. ASH had requested CMS to waive this reduction in the CF due to the ongoing financial hardships from the COVID-19 pandemic.

ASH members should note that in addition to the reduction in the CF for 2022, Congress has mandated a 2% across the board reduction (sequester) in Medicare payments, and the PAYGO (Pay-As-You-Go) legislation passed earlier this year includes a 4 % reduction in Medicare payments. If Congress does not take action on these planned cuts, physicians will face a 9.75% reduction in reimbursement.

Practice Expense Changes – Impact on Hematology/Oncology

CMS finalized the phased-in implementation of the supplies and equipment pricing data used to calculate practice expense. In addition, CMS finalized its proposal to update labor rates, but decided to phase-in the changes over 4 years with the final updated labor rates becoming effective 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. ASH supported the phased-in implementation to help reduce the impact on specialties, such as hematology.

The direct practice expense data within the MPFS is a fixed pool of resources, and therefore, implementation of these increased costs results in a redistribution. Specialties that rely primarily on clinical labor rather than supplies or equipment will receive the largest increases relative to other specialties. In contrast, specialties that rely primarily on supplies or equipment items are anticipated to receive the largest decreases relative to other specialties. Anticipated clinical labor pricing effect on hematology/oncology is a 2% reduction (Table 9).

Final Rule Impact on Hematology and Hematology/Oncology and E/M Services

Attached to this summary is a specialty impact chart that reflects the impact on specialties for the provisions in the final rule. The specialty impact chart is showing an overall decrease in payment for hematology/oncology services of 1 %, due to reductions in practice expense values. It is important

to note, however, that this chart does not take into account all of the payment reductions discussed above and therefore, the -1% for hematology/oncology will likely be closer to -5%. Also attached are the specialty specific charts for hematology and hematology/oncology and E/M services.

The most significant impact on payment is for office-based Hematology/Oncology services where proposed reductions range from 6% – 10% for most services, but reductions are significantly greater (10% -20%) for the apheresis and photopheresis codes. This is largely due to the changes to the labor component used to calculate the Practice Expense RVUs being phased in over the next 4 years. Reductions in hospital-based services and E/M services are also proposed, but these are largely due to the 3.75% reduction in the CF, which Congress may act to reinstate.

Evaluation and Management

Split or Shared Visits

A split (or shared visit) refers to an E/M visit performed (split or shared) by both a physician and a non-physician practitioner (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 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 visit 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 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 Physicians Reporting of E/M Services

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 physicians performing qualifying activities listed by CPT (with or without direct patient contact on that 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

CMS finalized payment for Category 3 telehealth services through the end of 2023. Category 3 was created in the CY 2021 MPFS final rule to describe services that were added to the Medicare telehealth services list during the COVID-19 public health emergency (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. CMS believes extending coverage until the end of 2023 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 finalized removing the geographic restrictions and permitting 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 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. While ASH has continued to request permanent removal of the geographic restrictions and to permit the home as an originating site for all telehealth services, CMS is implementing the changes only for mental health services as was mandated by the Consolidated Appropriations Act of 2021. CMS continues to state that they do not have the authority to make these changes for other services without Congressional action.

CMS is ending coverage for audio-only E/M services (CPT codes 99441-99443) at the end of the COVID-19 PHE. ASH continues to oppose this policy and requests permanent coverage for and equitable payment of these codes.

Virtual check-in

CMS is finalizing the proposal to permanently establish separate coding and payment for the longer virtual check-in service described by HCPCS code G2252 for CY 2022 using a crosswalk to the value of CPT code 99442.

Quality Payment Program - Merit-based Incentive Payment System (MIPS) Value Pathways

CMS is moving forward with the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) believing that MVPs allow for a more cohesive participation experience by connecting activities and measures from the 4 MIPS performance categories that are relevant to a specialty, medical condition, or a particular population. CMS finalized an initial set of MVPs: Rheumatology, Stroke Care and Prevention, Heart Disease, Chronic Disease Management, Emergency Medicine, Lower Extremity Joint Repair, and Anesthesia. ASH had commented that the creation of MVPs requires sufficient and meaningful measures and that measures take time and expertise to develop.