Holland & Knight

Final CY 2022 Medicare Payment Rule Highlights

Release Date: Nov. 2, 2021 | Effective Date: Jan. 1, 2022

I. Physician Fee Schedule (PFS) (Press Release | Fact Sheet | Rule Text)

- ***Conversion Factor (CF)*** CMS finalized a 2022 CF of $33.59, a $1.30 decrease from $34.89.
- ***Clinical Labor Rate Pricing Updates*** Following stakeholder feedback, CMS will phase in over four years.
- ***Critical care services*- CMS did *not* finalize its proposal to bundle critical care visits with procedure codes that have a global surgical period** and will instead maintain its current policy that critical care visits may be separately paid in addition to a procedure with a global surgical period, as long as the critical care service is unrelated to the procedure. CMS is creating a new mandatory modifier to identify these cases.
- ***Telehealth*** CMS will retain certain services on Medicare's approved telehealth list through 2023 and others added on a temporary basis through 2021 or the end of the COVID Public Health Emergency (PHE). CMS permanently adopted payment for longer virtual check-ins and broadened the definition of interactive telecommunications systems. In accordance with the Consolidated Appropriations Act, CMS permanently removed geographic restrictions and added the beneficiary's home as a permissible originating site for mental health and substance use disorder treatment services provided in-person visit requirements are met, which includes an in-person visit within the prior 6 months **and at least every year thereafter, with new exceptions for individual beneficiary circumstances.**
- ***Split/Shared E/M Visits*** The "substantive portion" of the visit can be based on history, physical exam, **medical decision-making** (MDM), or total time (except critical care services must be based on total time).
- ***Teaching Physician Services*** Only time spent by the teaching physician in qualifying activities, including when present with the resident, can count towards visit level selection. Under the primary care exception, only MDM (not time) can be used to select visit level.
- ***Therapy Services*** CMS is revising the de minimis standard to allow a 15-minute service to be billed without the CQ/CO modifier in cases when the PT/OT meets the 8-minute midpoint cutoff on their own.
- ***COVID Vaccine Rates*** CMS will maintain the current rate of $40 per dose through the end of the CY in which the PHE ends, after which it will align with rates for other Part B preventive vaccines, presently $30.
- ***Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)*** CMS finalized several provisions aimed at expanding access underserved and vulnerable populations including expanded virtual mental health services, increasing per-visit payment limits, and expanding the scope of billing for transitional and chronic care management services.
- ***E-prescribing*** CMS finalized several new exceptions.
- ***Appropriate Use Criteria (AUC)*** CMS delayed the payment penalty phase to Jan. 1, 2023 or the January following the end of the COVID PHE, whichever is later, made several claims processing edits, and clarified the scope of several hardship exceptions and modifiers.
- ***Medicare Shared Savings Program (MSSP)*** CMS finalized several changes including extending Web Interface and delaying increases to the quality performance standard.
- ***Merit-based Incentive Payment System (MIPS)*** CMS added social workers and certified nurse mid-wives as eligible providers, increased both performance thresholds, increased the weight of the Cost Category, and is moving forward with MIPS Value Pathways (MVPs). Click here for Qualified Payment Program resources ≫
- ***Medicare Diabetes Prevention Program*** CMS will shorten the program to one year but increase performance payments during that period. CMS also proposes to waive the $599 Medicare enrollment fee for all MDPP providers starting next year. Click here for a dedicated CMS fact sheet on the MDPP changes≫

*This is NOT an exhaustive list. Stay tuned for a more detailed analysis. Email suzanne.joy@hklaw.com with questions.

II. Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment Systems and Quality Reporting Programs (press release | fact sheet | rule text)

- ***Payment Rate Updates*** As a result of the COVID PHE, CMS is using CY 2019 claims data to set CY 2022 payment rates. CMS is increasing CY 2022 OPPS payment rates for hospitals that meet applicable quality reporting requirements by 2%, which reflects a projected hospital market basket increase of 2.7% reduced by 0.7% for the productivity adjustment. This is lower than CMS' proposed increase of 2.3%.
- ***Hospital Price Transparency Requirements*** CMS is finalizing proposals to increase the minimum civil monetary penalties based on the number of beds. Hospitals with a bed count of 30 or fewer will face fines of $300/day. Hospitals with greater than 30 beds will face fines of $10/bed/day up to $5,500 which amounts to annual penalties between $109,500 to just over two million dollars. Machine-readable files must be made accessible via automated searches and direct download.
- ***Inpatient Only Services List and ASC Covered Procedures List (CPL)*** CMS will reinstate just under 300 services to the inpatient only list and 255 services to the ASC CPL out of patient safety concerns. CMS also reinstated criteria and a nomination process for adding procedures to the ASC CPL.
- ***340B Drugs*** CMS is continuing the OPPS payment rate of average sales price minus 22.5% for certain separately payable drugs or biologicals acquired through the 340B Program. Rural sole community hospitals, children's hospitals, and PPS-exempt cancer hospitals would continue to be excepted from this policy.
- ***Non-Opioid Pain Management Drugs and Biologicals*** CMS will provide separate payment when they function as surgical supplies in the ASC setting provided they meet certain criteria, including a per-day cost above the OPPS drug packaging threshold.
- ***Pass-Through Drugs and Devices*** CMS is approving three new devices for pass-through status and will continue pass-through payments for 46 drugs and biologicals, including 27 whose status was set to expire.
- ***Radiation Oncology Model*** CMS finalized several changes including delaying the start date and baseline period, excluding liver cancers and brachytherapy services, and lowering discount factors.
- ***Hospital Outpatient/ASC Quality Reporting Programs*** CMS finalized several changes to the measures set and electronic data reporting requirements, including required use of the latest Certified EHR Technology.