American Association of Neurological Surgeons | AANS/CNS Washington Committee for Neurological Surgery | Congress of Neurological Surgeons

2022 Medicare Physician Fee Schedule Final Rule

Overview

On Nov. 2, 2021, the Centers for Medicare & Medicaid Services (CMS) released the CY 2022 Medicare Physician Fee Schedule (MPFS) Final Rule. The agency estimates the final rule will have no impact on overall neurosurgical payments. However, absent Congressional action, neurosurgeons face multiple Medicare payment cuts, including cuts stemming from the lower conversion factor — $34.89 in 2021 to $33.59 in 2022 — due primarily to the discontinuation of the 3.75% payment adjustment included in the Consolidated Appropriations Act, 2021. With the 2% Medicare sequester set to resume next year and additional Medicare payment cuts of up to 4% possible under pay-as-you-go rules, neurosurgeons face cuts of nearly 10% in 2022. The final rule also includes provisions related to the Quality Payment Program (QPP) and Medicare's Appropriate Use Criteria (AUC) Program for advanced diagnostic imaging.

A fact sheet is available here. Below are highlights of the final rule, noting any responses to our Sept. 10, 2021 comment letter regarding the Proposed Rule.

Reimbursement Issues

CMS Review of RUC-passed Neurosurgery Codes

Below is a list of new codes presented to the RUC by the AANS and the CNS. Neurosurgery and the AMA RUC disputed the proposed changes in our comment letters. In addition, RUC and CPT advisors from the AANS, CNS, NASS, ISASS and AAOS held a virtual meeting with CMS staff regarding the work relative value units (wRVUs) for the new arthrodesis decompression codes — CPT codes 63052 and 63053 — on Sept. 10, 2021. As a result, CMS increased the values of those codes in the final rule, although not to the RUC-recommended level.

CPT Code	Descriptor	RUC-passed wRVU	CMS Proposed wRVU	CMS Final wRVU
61736	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; single trajectory for 1 simple lesion	20.00	19.06	19.06
61737	Laser interstitial thermal therapy (LITT) of lesion, intracranial, including burr hole(s), with magnetic resonance imaging guidance, when performed; multiple trajectories for multiple or complex lesion(s)	24.00	22.67	22.67
63652	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment	5.55	3.08	4.25

CPT Code	Descriptor	RUC-passed wRVU	CMS Proposed wRVU	CMS Final wRVU
63653	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment	4.44	2.31	3.19

Potentially Misvalued Codes

- **CPT Code 22867**. Last year, CMS received multiple requests to designate CPT code 22867 (Insertion of interlaminar/interspinous process stabilization/distraction device, without fusion, including image guidance when performed, with open decompression, lumbar; single level) as potentially misvalued. CMS referred the code to the RUC for reconsideration, and the AANS and the CNS joined other spine societies in presenting data to support the RUC-passed value and refute the CMS decrease. In the 2022 final rule, CMS confirmed it would increase the wRVUs from 13.50 to 15.00.

- **CPT Code 22551**. CMS noted that on Feb. 2, 2021, LifeNet Health, a manufacturer of allograft bio-implants, nominated CPT code 22551 (Arthrodesis, anterior interbody, including disc space preparation, discectomy) as misvalued. In the CY 2022 proposed rule, CMS disagreed with the company's analysis and confirmed that the agency would not designate the code as misvalued.

Practice Expense

- **Overrides for Practice Expense (PE) Relative Value Unit (RVU) Methodology and Professional Liability Insurance (PLI) RVUs for Low Volume Service Codes.** The AANS and the CNS continue to support using "Expected Specialty Overrides" for low-volume service codes, and CMS will continue to do so, based on recommendations from the RUC.

- **Clinical Labor Update**. Calendar Year 2022 is the final year of a multi-year phased update for PE for supplies and equipment. In the 2022 final rule, CMS confirmed that the agency would update PE clinical labor pricing, as data for this component is nearly 20 years old and will phase in the changes over four years. The AANS and the CNS supported the update with a multi-year transition period.

- **Pre-service Time for Procedures Converted from 090 to 000 day Global Services.** In the final rule, CMS claimed to agree that direct PE inputs for each service should be evaluated on a case-by-case basis based medically necessary. However, for two 000-day global code set — including the new LITT codes, for which the RUC agreed the pre-service clinical labor time is the same as a 90-day procedure — CMS reduced the RUC recommended clinical labor time. Instead, the agency used lower 000-day or 10-day global period "standards" for "extensive use of clinical staff," significantly less than the 90-day global pre-service time. CMS stated they continue to support the setting and maintaining of clinical labor standards. In general, the agency believes that no pre-service clinical labor time exists for 000-day global codes unless significant justification is provided. This is particularly a concern for codes, such as the LITT codes, in which there is significantly different post-operative care, and a 000-day global period would allow post-operative visits to be reported separately. The AANS, CNS and others have argued that major surgical procedures require similar pre-clinical staff time, regardless of the global period.

Evaluation and Management Issues

Once again, CMS failed to incorporate increased values for outpatient/office Evaluation and Management (E/M) services into the global surgical codes. On July 22, 2021, the AANS and the CNS

joined 22 other surgical societies in a letter to CMS addressing the issue. In the final rule, CMS acknowledged receiving comments requesting that the 2021 value increases to the office and outpatient E/M code set should be extended to 10- and 90-day global codes. However, the agency stated that it is not addressing these comments because they are "not within the scope of topics addressed in this CY 2022 PFS rulemaking." However, CMS addresses several other refinements to current E/M policies, including split (or shared) E/M visits, critical care services and services furnished by teaching physicians involving residents. Below are highlights:

- **Split/Shared Visits**. CMS finalized its proposal to define split (or shared) E/M visits as visits provided in a facility setting by a physician and a non-physician provider in the same group and clarifies that only one of the practitioners must perform the "in person" part of an E/M visit when it is split (or shared). This person does not need to be the same one who performs the "substantive portion" of the visit.

- **Critical Care Services**. In the final rule, CMS notes it will allow critical care services to be furnished concurrently to the same patient on the same day by more than one practitioner representing more than one specialty and allow critical care services to be delivered as split (or shared) visits. However, CMS stated it might revisit this issue as the agency continues to be concerned about overlapping work.

  CMS had proposed to prohibit reporting of critical care visits during the same time as a procedure with a global surgical period, even for unrelated conditions. However, based on stakeholder comments, including neurosurgery, CMS will not finalize the proposal to bundle critical care visits with procedure codes that have a global surgical period. Instead, CMS will maintain the 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. Preoperative and/or post-operative critical care may be paid in addition to the procedure if the patient is critically ill (i.e., meets the definition of critical care), requires the physician's full attention and is unrelated to the specific anatomic injury general surgical procedure performed. CMS will create a new modifier to identify that the critical care is unrelated to the procedure

- **Teaching Physician Time**. CMS finalized its proposal permitting the time when a teaching physician is present to be included when determining the E/M visit level. For the primary care exception, which does not require proximity of the attending physician, only medical decision-making may be used to select the visit level.

National Coverage Determination Change for PET Scans

As part of an initiative begun last year to sunset outdated National Coverage Determinations (NCDs), CMS has proposed discontinuing two NCDs, including an element of the NCD for PET Scans. NCD 220.6 prohibits coverage of positron emission tomography (PET) imaging unless a PET imaging technique and indication are expressly covered under other subsections of the NCD. Currently, Medicare Administrative Contractors (MACs) have the discretion to cover PET using radiopharmaceuticals for FDA labeled indications for oncologic imaging. However, PET imaging is otherwise not covered, with a few exceptions. In the final rule, CMS notes that the agency will go through with the adjustments to the NCD for PET scans, allowing the MACs increased discretion to cover non-oncologic indications.

Expansion of Telehealth

CMS will not add any new services to the list of reimbursable telehealth services, including neurostimulator electronic analysis of pulse generator/transmitter CPT codes 95970-95972 and neurostimulators, programming CPT codes 95983; 95984. CMS will extend reimbursement for certain telehealth services added during the COVID-19 Public Health Emergency (PHE) to the end of 2023. As required by the Consolidated Appropriations Act, 2021, CMS will also lift the geographic restrictions on telehealth services.

Electronic Prescribing of Controlled Substance

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment for Patients and Communities (SUPPORT) Act requires electronic prescribing of certain controlled substances covered through Medicare Part D. CMS finalized some exceptions and a one-year delay in implementation. Exceptions would be made for prescribers who write 100 or fewer controlled substance prescriptions in a calendar year and those in the geographic area of a natural disaster or who are granted a waiver based on unusual circumstances.

Care Management for Patients with Chronic Pain

CMS requested feedback on ways to improve care management for patients with chronic pain. The AANS and the CNS noted their support for patient-centered management of pain and for 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. We also urged CMS to prohibit Part D plans from imposing prior authorization and quantity limits on buprenorphine.

Open Payments Program

CMS is finalizing its proposals for several changes to the Open Payments Program, which requires manufacturers to report payment in three categories: 1) general (for items such as food and travel); 2) research; and 3) ownership interest. In the past, CMS has permitted the delay of the publication of records if the manufacturer deems them to contain confidential, proprietary information for current device development. In the future, CMS will allow such a delay only for research payments, not for other categories. In addition, CMS will create a new required field for teaching hospital records to address requests from researchers for greater clarity of payments to those entities. Finally, CMS will include a specific definition for physician-owned distributorships (PODs) and make an explicit requirement for PODs to be clearly and separately identified. Neurosurgery supported the latter provision, and the AANS and the CNS both include investment in PODs on their conflict of interest disclosure forms.

Quality Provisions

MIPS Value Pathways

CMS finalized its decision to proceed with the Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs), starting with an introductory and voluntary set of seven MVPs in 2023, including one focused on Stroke Care. As a result of AANS and CNS pushback, CMS did not propose or finalize a draft Spine MVP that it had attempted to assemble earlier in the year, although CMS intends to introduce more MVPs over time. The intent of MVPs is to make reporting across the four MIPS performance categories more clinically focused, cohesive, and less burdensome. However, for the foreseeable future, MVPs will continue to rely on the same weak inventory of quality measures and complicated scoring rules as traditional MIPS. They will, thus, do little to improve the program. Some additional details include:

- CMS finalized its proposal to move forward with MVPs starting in 2023 with an initial set of seven optional MVPs: Rheumatology, Stroke Care, Ischemic Heart Disease, Chronic Disease Management, Emergency Medicine, Lower Extremity Joint Repair and Anesthesia.
- Clinicians/groups/alternative payment model (APM) entities would have the option to participate in MIPS via an MVP or continue participating via traditional MIPS.
- The reporting burden of MVP participants would be slightly less than traditional MIPS, requiring the selection of four measures, including an outcome or high priority measure (versus six measures) and one to two Improvement Activities (versus two to four activities). MVP participants will also be scored on population health measures that are automatically calculated by CMS based on administrative claims so long as case minimums are met and predetermined

cost measures. The complete set of Promoting Interoperability measures is also required for each MVP participant unless the clinician qualifies for an exemption (e.g., hospital-based).

- CMS finalized that MVP registration would be open from April 1 through November 30 of each performance year.
- CMS has its eye on potentially sunsetting traditional MIPS and making MVPs mandatory in the future.
- CMS will allow voluntary "subgroup" reporting for those participating through MVPs. With subgroup reporting, a subset of specialists in a larger TIN would be able to peel off from the larger group for MIPS measure selection and reporting purposes. CMS delayed, until 2026 (rather than 2025), the requirement for multispecialty groups to form subgroups to report MVPs.
- Qualified Clinical Data Registries (QCDRs) will be required to support MVPs relevant to the specialties they support, as well as subgroup reporting beginning in 2023. In response to concerns, CMS noted that at this time, it does not intend on assigning specific MVPs to a third-party intermediary. However, CMS notes that it is "required for QCDRs…to identify (CMS Approved) MVPs that are relevant to the clinicians they support and report on those."

Traditional MIPS

As required by statute, CMS finalized the following performance category weights for 2022: Quality: 30%; Cost: 30%; IA: 15%; and PI: 25%. Also, as required by statute, CMS finalized increasing the MIPS performance threshold (i.e., minimum points needed to avoid a penalty) to 75 points, up from 60 points. The exceptional performance threshold will also be increased to 89 points, up from 85 points. Under the statute, 2022 is the last performance year that exceptional performance will be rewarded. CMS will continue to double the complex patient bonus available for the 2021 and 2022 MIPS performance years — a policy first adopted in 2019 due to COVID-19. However, CMS adopted a revised complex patient bonus calculation, beginning with 2022, to better target clinicians who have a higher share of socially and/or medically complex patients.

Other finalized policies that affect specific performance categories include:

- **Quality Category**.
    - Adoption of a new administrative claims measure (calculated automatically by CMS for clinicians and groups who are assigned a minimum number of cases): Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions
    - Removal of the following surgical measures:
        - 21: Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin
        - 23: VTE Prophylaxis
    - CMS decided to maintain #317: Screening for High Blood Pressure despite its proposal to remove it. However, CMS intends to remove this measure in the future.
    - As proposed, CMS will maintain the data completeness criteria threshold at 70% for the 2022 and 2023 MIPS performance periods rather than bump it up to 80%.
    - After analyzing the available data, CMS determined there was no need to use 2022 performance year benchmarks exclusively or to use a different baseline period (such as CY 2019) to create historical benchmarks resulting from COVID disruptions. CMS will create historical benchmarks using 2020 performance data.
    - CMS finalized multiple scoring policies that will make it more challenging to meet higher performance thresholds and avoid a penalty, including:

- Ending bonus points for reporting additional outcome/high priority measures and using end-to-end electronic reporting starting in 2022.
- Starting in 2023 (rather than 2022, as proposed), CMS will remove this floor, and these measures will receive 1-10 points.
- For 2022, measures without a benchmark will continue to earn 3 points, but starting in 2023, measures without a benchmark or that don't meet the case minimum will earn zero points. Small practices will continue to earn 3 points.
- CMS will maintain the 3-point floor for measures with a benchmark, case minimum, and data completeness for 2022. However, for 2023, CMS will remove this floor, and these measures will receive 1-10 points.
- Rather than finalize its proposal to provide a 5-point floor for the first two performance years of new quality measures, CMS concluded that beginning in 2022, new measures will have a 7-point scoring floor for the first performance period and a 5-point scoring floor for their second performance period (i.e., in their first year, new measures will earn 7 points if no benchmark can be created, provided the case minimum and data completeness are met). New measures that can be scored against a benchmark will — up to 10 points.

- **Promoting Interoperability.**

  + CMS finalized for 2022 its proposal to require two of the measures associated with the Public Health and Clinical Data Exchange Objective, beginning with the performance period in CY 2022 (unless an exclusion applies):
    - Immunization Registry Reporting; and
    - Electronic Case Reporting.

    Bonus points will be awarded for reporting on any one of the following:
    - Public Health Registry Reporting;
    - Clinical Data Registry Reporting; or
    - Syndromic Surveillance Reporting measure.
  + CMS finalized for 2022 its proposed new measure where clinicians must attest (yes/no) to conducting an annual assessment of the High Priority Guide of the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides).
  + CMS did not finalize its proposal to modify the Provide Patients Electronic Access to Their Health Information measure to require patient health information to remain available to the patient to access indefinitely, starting with a date of service of Jan. 1, 2016.

- **Improvement Activities.** CMS finalized seven new IAs, as proposed, including three focused on health equity. CMS also modified 15 IAs and removed six IAs.

Advanced Alternative Payment Models

Clinicians who receive a substantial portion of their reimbursement or see a significant number of patients under what CMS designates as an Advanced APM are considered Qualifying Participants (QPs). "Advanced" APMs bear more than nominal risk and must have a certain percentage of their participating clinicians using federally certified EHR technology. For 2021 and 2022, these QPs are exempt from MIPS and instead qualify for a lump sum bonus payment in 2023 and 2024, respectively, based on 5% of their Part B allowable charges for covered professional services in 2022 and 2023 (across all TINs they may practice under). However, 2022 is the last year clinicians will be eligible for the 5% incentive payment under this track of the QPP.

Under MACRA, the payment and patient thresholds used to determine QP eligibility increase over time. However, the Consolidated Appropriations Act, 2021, froze these QP thresholds at 2020 levels for

performance years 2021 and 2022 to ensure clinicians could still qualify as QPs in light of COVID-19 disruptions to practice. Rather than increasing the payment threshold to 75% and the patient threshold to 50%, the thresholds will remain as follows:

Performance Year	**2020**	**2021**	**2022**
Payment Year	**2022**	**2023**	**2024**
QP Payment Amount Threshold	**50%**	**50%**	**50%**
QP Patient Count Threshold	**35%**	**35%**	**35%**

Appropriate Use Criteria Program

CMS finalized its decision to delay the payment penalty phase of the Appropriate Use Criteria Program for advanced diagnostic imaging to the later of Jan. 1, 2023, or the January that follows the declared end of the PHE. CMS also finalized several claims processing solutions to ensure accurate identification of claims that are and are not subject to the AUC program requirements.

Medicare Shared Savings Program (MSSP) ACOs

CMS finalized a more extended transition for ACOs to prepare for reporting electronic clinical quality measures (eCQMs) and MIPS clinical quality measures (MIPS CQM) under the APM Performance Pathway (APP) finalized last year. Under this policy, MSSP ACOs can continue to report through the CMS Web Interface for an additional three years — through performance year 2024. This policy responds to concerns about the transition to all-payer eCQM/MIPS CQMs, including aggregating all-payer data across multiple practices that participate in the same ACO and across multiple EHRs.

CMS also finalized delaying the increase in the quality performance standard ACOs must meet to be eligible to share in savings until PY 2023 and additional revisions to encourage ACOs to report all-payer measures.

Finally, CMS finalized policies to lower potential barriers to ACO participation in two-sided risk models, where providers still share in the savings but are also responsible for some of the loss if spending is above the benchmark. CMS also revised the definition of primary care services used in MSSP beneficiary assignment.