AAOS
American Association of Orthopaedic Surgeons

CY 2022 Medicare Physician Fee Schedule Final Rule

The Calendar Year (CY) 2022 Medicare Physician Fee Schedule final rule was released on November 2, 2021 by the Centers for Medicare & Medicaid Services (CMS). The annual payment rule sets policy for physicians participating in the Medicare program and makes updates to the Quality Payment Program. AAOS submitted formal comments to CMS in September. The outline below compares what AAOS advocated for and what was made final in the rule. The majority of the regulations will take effect on January 1, 2022.

Topic	AAOS Comment/Recommendation	Finalized Policy
Conversion Factor	AAOS strongly urged CMS to maintain the current funding levels. This is critical to preserving access to patient care during the COVID-19 public health emergency.	The conversion factor, which is the primary factor determining increases or decreases to overall payment rates in the physician fee schedule, will be reduced from $34.89 to $33.58 (-3.75%). This change is largely a result of the planned expiration of the 3.75% increase that was implemented through congressional action at the end of 2020 in the Consolidated Appropriations Act. The estimated combined impact of the work, practice expense, and malpractice RVUs and the expiration of the 3.75% increase from Congress will be a 2.7% total decrease to the 2022 allowed charges for orthopedic surgery.
Appropriate Use Criteria (AUC)	CMS is once again proposing to delay the AUC for advanced diagnostic imaging until at least January 1, 2023, or the first January following the end of the public health emergency. Although AAOS is supportive of programs that improve quality and reduce unnecessary testing, we are concerned that the implementation of the AUC program will detract from the developments of the Quality Payment	CMS is finalizing the proposal to begin the penalty phase of the AUC program on the later of January 1, 2023 ***or*** the January 1 that proceeds the end of the public health emergency.

	Program (QPP) made in the years since the AUC program was signed into law.	
Merit-based Incentive Payment System (MIPS)	No comment.	CMS finalized several MIPS scoring policies that will make it incrementally more difficult to avoid a negative payment adjustment in the coming years including: Shifting the performance category weights for Performance Year (PY) 2022 to increase the impact of Cost on final scores: • Quality: 30% (-10% from CY 2021) • Cost: 30% (+10% from CY 2021) • Promoting Interoperability: 25% (no change) • Improvement Activities: 15% (no change) Beginning with PY 2022, The MIPS performance threshold for PY 2022 is 75 points. This is the minimum score needed to avoid a negative payment adjustment. Beginning with PY 2022, there will be no bonus points awarded for reporting additional outcome and high priority measures, beyond the one required, and no bonus points awarded for measures that meet end-to-end electronic reporting criteria Beginning with PY 2023, the 3-point floor for quality measures without a benchmark or those that do not meet the case minimum will be removed unless reported by a small

		practice. (Note: Small practices will continue to earn 3 points.)
Cost Measures	AAOS shared concerns for the limited cost measure inventory and recommended that CMS provide Medicare claims data, cost performance data, and funding to help specialty societies identify and develop clinically appropriate cost measures.	CMS is implementing a process of cost measure development by stakeholders, including a call for cost measures, beginning in CY 2022 for earliest adoption into the MIPS program by PY 2024. CMS plans to apply cost measure development prioritization criteria to an environmental scan that would inform stakeholders of gaps in the cost measure inventory and suggested areas for measure development.
Subgroup Reporting	In general, AAOS supported the concept of a subgroup reporting option; however, we sought clarification from CMS on who and how MVPs will be defined. AAOS also expressed concern for using Medicare Provider Enrollment, Chain, and Ownership System (PECOS) specialty data to determine subgroup composition and restricting subgroup reporting to a single specialty.	Subgroup reporting will be a reporting option for only the MVP and APM Performance Pathway (APP) and will be voluntary for PY 2023, 2024, and 2025. Multispecialty groups that report through an MVP will have to report as subgroups beginning with PY 2026. Subgroups will self-select and, if reporting via MVP, follow the MVP participant registration process.
MIPS Value Pathway (MVP)	AAOS appreciated delaying MVP implementation until the 2023 Performance Year to allow more time for developers and CMS to grow the MVP inventory with the caveat that CMS should reinstate the APM Scoring Standard should they feel the MVP program will not be ready by 2023.	CMS finalized proposal to begin implementing MVPs with PY 2023. MVP reporting will be voluntary and participants will need to register between April 1 and November 30 of the performance year. CMS acknowledged the need to build a robust inventory of MVPs

		before considering the sunset of traditional MIPS. They are seeking additional public comment.
	Based on our experience submitting a candidate MVP in 2021, AAOS recommended CMS maintain a list of MVPs under consideration on the QPP website along with the MVP development point of contact and publish a list of topics it considers high priority for MVP development.	Beginning with PY 2023 CMS will implement an annual maintenance process for finalized MVPs, through which stakeholders may submit recommendations to revise established MVPs. Revisions will be made through rulemaking. To build out a comprehensive MVP portfolio, CMS intend to identify additional MVP priority areas for development and include those within guidance materials for the MVP candidate submission process.
	AAOS expressed concern for the lack of strong incentives to encourage MVP reporting over Traditional MIPS. We suggested the addition of multi-category credit, an introductory year hold harmless scoring policy, and automatic full Improvement Activity credit for reporting through a QCDR.	CMS did not add any additional incentives to MVP scoring or reporting. The agency does not believe it has the discretion to have a "hold harmless" approach for clinicians reporting an MVP nor does it want to "introduce bonuses for reporting MVPs or other incentives that may mask performance and artificially inflate final scores." However, CMS indicates incentive ideas are being explored and will be addressed through future rulemaking.
	AAOS was generally supportive of the measures included in the proposed Improving Care for Lower Extremity Joint Repair MVP and were happy to see feedback from meetings with the agency was incorporated into the proposal.	Overall, the finalized LEJR MVP is in alignment with AAOS's recommendations. CMS added an additional quality measure (Q024: Communication

		with the Physician or Other Clinician Managing On-Going Care Post Fracture for Men and Women Aged 50 Years and Older) to the Improving Care for Lower Extremity Joint Repair MVP, which brings the number of reportable quality measures up to seven. In the future, AAOS hopes to see QCDR measures added to this MVP.
Third Party Intermediaries	Though it was not addressed in the proposed rule, AAOS continued to strongly urge CMS to reconsider delaying implementation of QCDR measure testing to the clinician- level and pre-submission data collection until at least one year after the PHE ends.	Based on public comments, CMS is considering proposing in next year's rulemaking to further delay this requirement for traditional MIPS until the CY 2024 performance period/2026 payment year.
Valuation of Specific Codes For CPT Code 28002 (Incision and drainage below fascia, with or without tendon sheath involvement, foot; single bursal space) the RUC recommended a work RVU of 3.50 which CMS disagrees with, proposing a work RVU of 2.79. CMS reached this proposed RVU by selecting a crosswalk closer to the survey's 25th percentile. AAOS has concerns regarding the crosswalk and the methodology used by CMS.	AAOS strongly urged CMS to accept a work RVU of 3.50 for CPT code 28002, stressing the importance of taking intensity level into account as the survey 25th percentile is not a justified point for valuing this service within the code family.	CMS is finalizing the work RVU value of 2.79 for CPT code 28002.
Split/Shared Services	AAOS strongly urged CMS not to revise the guidelines to split/shared E/M services as it will create confusion among providers.	CMS is finalizing their definition of split (or shared) visits as proposed. Regarding definitions of

CMS proposed to refine policies for split (or shared) E/M visits to better reflect the current practice of medicine, the evolving role of non-physician practitioners (NPPs) as members of the medical team, and to clarify conditions of payment that must be met to bill Medicare for these services.	AAOS also urged CMS to consider revising the definition for "substantive portion" to be based on medical decision making (MDM) and not time as the determining factor of who bills for the split/shared service should be focused on the practitioner that contributed the most towards the MDM as they are ascertaining the majority of the risk. Lastly, AAOS urged CMS not to require a modifier to be reported for split/shared services, as this will be an additional administrative burden.	"substantive portion", CMS is modifying their proposed policy for one transitional year. For CY 2022, with the exception for critical care visits, the "substantive portion" will be defined as one of three key components (history, exam or MDM), or more than half of the total time spent by the physician and NPP performing the split (or shared) visit). The practitioner who spends more than half of the total time, or performs the history, exam, or MDM can be considered to have performed the substantive portion and can bill for the split (or shared) E/M visit, as proposed. Lastly, CMS disagrees that reporting a modifier on a claim comprises a substantial administrative burden and believes that any potential burden is outweighed by the policy considerations of quality, payment accuracy and program integrity. CMS is finalizing their proposal for CY 2022 which will require a modifier to be reported on the claim to identify split (or shared) visits.
Telehealth	AAOS urged CMS to continue the current temporary PHE flexibilities for telehealth on a permanent basis, and not expire at the end of the year in which the PHE for COVID-19 ends or December 31, 2021.	Finalized certain temporary services added to the Medicare telehealth services list will remain on the list through December 31, 2023.
	AAOS recommended that CMS work with the CPT Editorial Panel to editorially revise telephone CPT codes 99441-99443 so that these CPT codes may be consistently reported by all payors, and	CMS finalized to permanently establish separate coding and payment for the longer virtual check-in service described by HCPCS code G2252 for CY 2022

	for CMS to permanently adopt coding and payment for HCPCS Level II code G2252, *(virtual check-in service)* and continue a direct crosswalk of relative value units to CPT code 99442 (*Telephone evaluation and management service).*	using a crosswalk to the value of CPT code 99442, as proposed. CMS agreed to include CPT codes 99441, 99442, and 99443 in the definition of primary care services used for beneficiary assignment until they are no longer payable under the PFS FFS payment policies. CMS also finalized the revision the existing definition of primary care services for purposes of beneficiary assignment in order to include CPT codes 99441, 99442, and 99443 until they are no longer payable under Medicare FFS payment policies.
	AAOS supported the development of a CPT modifier to indicate when a service is provided via an audio-only technology (primarily via telephone).	CMS finalized a requirement for the use of a new modifier for services furnished using audio-only communications, which would serve to verify that the practitioner had the capability to provide two-way, audio/video technology, but instead, used audio-only technology due to beneficiary choice or limitations.
	AAOS requested again to permanently allow reimbursement for audio-only telehealth services.	CMS finalized the use of an audio-only interactive telecommunications system to be limited to mental health services when there is a capability to furnish two-way, audio/video communications, but cannot or will not be used. CMS amended the current definition of interactive

		telecommunications system for telehealth services to include audio-only communications technology when used for telehealth services for the diagnosis, evaluation, or treatment of mental health disorders furnished to established patients in their homes under certain circumstances.