Critical 2022 Billing & Coding Updates

For Your Medical Practice

Disclaimer

No planner or faculty of this program has any relevant financial relationship to disclose

Before We Begin:

We only have approximately 45 minutes together today, allowing for an additional few minutes for Q&A. There are a large number of slides in this presentation, and we will likely not have time to cover all of them in depth. A number of the slides are simply for your reference and resource; some to more definitively clarify what we are discussing. Please review them carefully – I think you'll find them all helpful.

Thank you all for giving up your time to be with us!

Mary Jean Sage

About This Manual

The material in this manual was written by practice management consultants. Any advice or information contained in this manual should not be construed as legal advice. When a legal question arises, consult your attorney for appropriate advice.

The information presented in this manual is extracted from official government and industry publications. We make every attempt to assure that information is accurate; however, no warranty or guarantee is given that this information is error-free and we accept no responsibility or liability should an error occur.

CPT codes used in this manual are excerpts from the current edition of the CPT (Current Procedural Terminology) book, are not intended to be used to code from and are for instructional purposes only.

It is strongly advised that all providers purchase and maintain up to date copies of CPT. CPT is copyrighted property of the American Medical Association.

Today's Agenda

Coding Sets

- ❑ ICD 10-CM Important Changes
- ❑ CPT Updates
- ❑ HCPCS Level II

Medicare

- ❑ Payment Provisions
- ❑ Latest on Telehealth
- ❑ E/M Visits
  - ❑ Shared/Split Visits
  - ❑ Critical Care
- ❑ RTM
- ❑ Other Coding/Payment Issues

MIPS (Medicare)

- ❑ Bonuses / Adjustments
- ❑ Categories
- ❑ Scoring

ICD-10-CM

Changes
Worth
Mentioning

General Coding Changes & Info ICD-10-CM

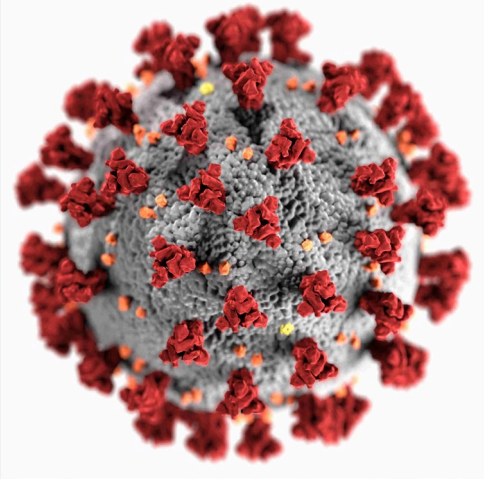
2022 Update (10/1/2021)

- ❑ 159 additions
- ❑ 32 deletions
- ❑ 20 revisions (small changes)

Total Codes for FY 2022 = 72,748

Effective 4/1/2022: updates will occur April (*expected to be brief****) and subsequent April and October***

Post Covid-19 Condition



U09.9 Post Covid-19 condition, unspecified

Note: This code enables establishment of a link with Covid-19. This code is not to be used in cases that are still presenting with active Covid-19. However, an exception is made in cases of re-infection with COVID-19, occurring with a condition related to prior COVID-19. Post acute sequela of COVD-19.

***Code first** the specific condition related to COVID-19 if known such as:*

chronic respiratory failure (J96.1-)

loss of smell (R43.8)

loss of taste (R43.8)

multisystem inflammatory system syndrome (M35.81)

pulmonary embolism (I26.-)

pulmonary fibrosis (J84.10)

COVID-19 let's review

Use U07.1 "as documented by the provider, or documentation of a positive Covid-19 test"

Use Covid-19 as the first diagnosis and respiratory or non-respiratory manifestations as additional diagnoses

Use Z20.822 for actual or suspected ***exposure*** to Covid-19, with or without symptoms

During the pandemic, **do not use Z11.52,** screening code

Covid-19 Review

- For signs and symptoms, without a definitive diagnosis, use sign/symptom code
- Add Z20.822 for actual or suspected contact
- Personal history of, use Z86.16 Personal history of Covid-19
- For follow up without symptoms or conditions, assign Z09 Encounter for follow-up examination after completed treatment for conditions other than malignant neoplasm, and Z86.16, Personal history of COVID-19

COVID 19: Partially, Unvaccinated Patients

- Effective 4/1/2022 – four (4) new codes
  - **Z28.31** (subcategory) – Underimmunization for COVID-19 status
    - **Z28.310** Unvaccinated for Covid-19 – *use this when a patient has not received at least one dose of a COVID-19 vaccine*
    - **Z28.311** Partially vaccinated for COVID-19 – *use this when a patient has received at least one dose of a multi-dose COVID-19 vaccine regimen, but has not received the full set of doses necessary to meet the CDC definition of "fully vaccinated"*
  - ***Z29.39*** Other Underimmunization status

CPT 2022

A Few Highlights

The 2022 CPT Code Set

- Overview
  - Category I – services and procedures performed by healthcare providers
  - Category II – supplemental tracking codes used primarily for performance management (quality reporting)
  - Category III – temporary codes describe emerging and experimental technologies, services, & procedures
- 405 Editorial Changes - 2022
  - 249 new codes (76 are Category III)
  - 63 deleted codes (26 are Category III)
  - 93 revised codes
- Incorporates series of 15 vaccine-specific codes to efficiently report and track COVID-19 immunization and administrative services
- 43% of editorial changes are tied to new technology services
- Addresses innovation in digital medicine services
  - Creation of five new CPT codes to report remote therapeutic monitoring (RTM)
- Created new codes for principal care management
  - Allows clinicians to report care management services for patients with one complex chronic condition

E/M Updates – New Principal Care Management (PCM) Codes

CPT Code	Description	Work RVU
99424	Principal are management services, for a single high-risk disease, with the following required elements: • one complex chronic condition expected to last at least 3 months, and that places the patient at significant risk of hospitalization, acute exacerbation/decompensation, functional decline, or death, • the condition requires development, monitoring, or revision of disease specific care plan, • the condition requires frequent adjustments in the medication regimen and/or the management of the condition is unusually complex due to comorbidities, • ongoing communication and care coordination between relevant practitioners furnishing care; first 30 minutes provided personally by a physician or other qualified health care professional, **per calendar month**	1.45
99425	each additional 30 minutes provided personally by a physician or other qualified health care professional, **per calendar month** (list separately in addition to code for primary procedure)	1.00
99426	first 30 minutes of clinical staff time directed by physician or other qualified health care professional, **per calendar month**	1.00
99427	each additional 30 minutes of clinical staff time directed by a physician or other qualified health care professional, **per calendar month** (List separately in additional to code for primary procedure)	0.71

E/M Updates – New Chronic Care Management (CCM) Code

CPT Code	Description	Work RVU
99437 (base code 99491)	Chronic care management services with the following required elements: • Multiple (two or more) chronic conditions expected to last at least 12 months, or util the death of the patient, • Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline, • Comprehensive care plan established, implemented, revised, or monitored; Each additional 30 minutes by a physician or other qualified health care professional, **per calendar month** (List separately in addition to code for primary procedure)	1.00

Care Management Updates - Important

- ❑ There are separate codes depending on who performed the service – physician or other qualified health professional **or** clinical staff
- ❑ There are many exclusions between codes so pay attention to the notes in the CPT book
- ❑ Make sure time is documented accurately (first 30 minutes vs additional 30 minutes)
- ❑ There were guideline revisions to other care management services – make sure you are prepared for proper documentation and payment
- ❑ Review the charts on pages 65-68 of CPT book for detailed explanation of when to use each code, who can perform each code, and the frequency of reporting

Surgery Updates – Guideline Note Highlights by Section

- **Integumentary system** (1004 – 19499)
  - Revised delivery implant code to further define implants as bioresorbable, biodegradable, non-biodegradable
  - Revised guidelines for simple repairs
- **Musculoskeletal** (20100 – 29999)
  - Revised guidelines now indicate all services in Musculoskeletal System section include application and removal of the first cast, splint or traction device, when performed
  - Further defined fracture/dislocation treatment
    - Manipulation, traction, closed treatment, percutaneous skeletal fixation, open treatment, external fixation
  - Revised guidelines for posterior, posterolateral or lateral transverse process technique
    - Added definitions
    - Changed “level” to “interspace” when addressing vertebrae

Surgery Update by Section

- **Cardiovascular** (33016 – 39599)
  - New codes have guidelines updates included in code section

- **Auditory** (69000 – 69979)
  - Several updates to osseointegrated implants including new codes for implantation and removal of the implant

Pathology and Laboratory Updates – Pathology Clinical Consultations

- Section includes new guidelines for the physician's review of pathology and laboratory findings frequently performed in the course of providing care to patients
- Review of pathology and laboratory test results occurs in conjunction with the provision of an E/M service
  - Considered part of the non-face-to-face time activities associated with the overall E/M service
  - Reviewing pathology and laboratory results is not a separately reportable service
  - Communicating the results to the patient, family, or caregiver of independent interpretation of results (not separately reported_, may constitute an E/M service
- New codes to be used to report consultation based on level of complexity – **for Pathology Clinical Consultation Services**
  - Must be done at the request of another physician or QHP
- There is a MDM chart on page 614 of CPT book – **use it!**

COVID-19 Vaccine Codes (Appendix Q)

Pfizer

COVID-19 Vaccine Codes - Pfizer

CPT/ HCPCS Code	Vaccine / Procedure Name	Manufacturer	Effective Date
91300	Pfizer-BioNTech Covid-19 Vaccine	Pfizer	12/11/20
0001A	Pfizer-BioNTech Covid-19 Vaccine Administration – **First Dose**	Pfizer	12/11/20
0002A	Pfizer-BioNTech Covid-19 Vaccine Administration – **Second Dose**	Pfizer	12/11/20
0003A	Pfizer-BioNTech Covid-19 Vaccine Administration – **Third Dose**	Pfizer	8/12/21
0004A	Pfizer-BioNTech Covid-19 Vaccine Administration – **Booster**	Pfizer	9/22/21
91307	Pfizer-BioNTech Covid-19 Pediatric Vaccine	Pfizer	10/29/21
0071A	Pfizer-BioNTech Covid-19 Pediatric Vaccine Admin. **First Dose**	Pfizer	10/29/21
0072A	Pfizer-BioNTech Covid-19 Pediatric Vaccine Admin. **Second Dose**	Pfizer	10-29-21

COVID-19 Vaccine Codes - Moderna

CPT/ HCPCS Code	Vaccine / Procedure Name	Manufacturer	Effective Date
91301	Moderna Covid-19 Vaccine	Moderna	12/18/20
0011A	Moderna Covid-19 Vaccine Administration – **First Dose**	Moderna	12/18/20
0012A	Moderna Covid-19 Vaccine Administration – **Second Dose**	Moderna	12/18/20
0013A	Moderna Covid-19 Vaccine Administration – **Third Dose**	Moderna	8/12/21
91306	Moderna Covid-19 Vaccine (Low Dose) - **Booster**	Moderna	10/20/21
0064A	Moderna Cvoid-19 Vaccine (Low Dose) Administration- **Booster**	Moderna	10/20/21

Covid-19 Vaccine Codes: Janssen (J & J)

CPT / HCPCS Code	Vaccine / Procedure Name	Manufacturer	Effective Date
91303	Janssen Covid-19 Vaccine	Janssen	2/27/21
0031A	Janssen Covid-19 Vaccine Administration – **Single Dose**	Janssen	2/7/21
0034A	Janssen Covid-19 Vaccine Administration - **Booster**	Janssen	10/20/21

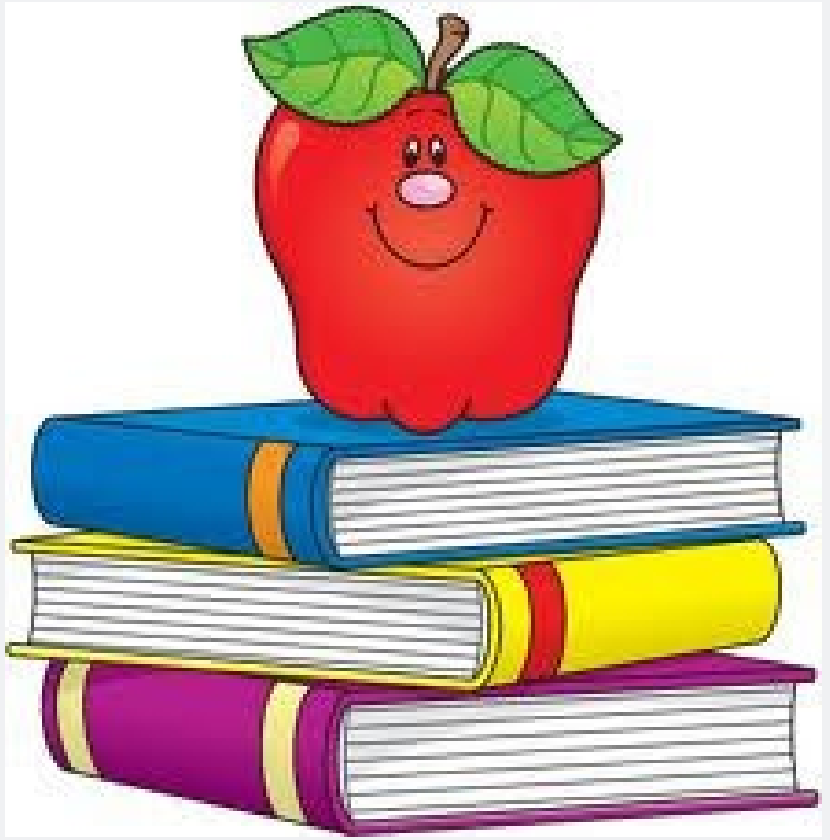
HCPCS Level II Changes

These Changes are Important as Well –

And

You Need to Get a New Book

Annually



HCPCS Level II (National Codes)

- ❑ 155 New Codes
- ❑ 63 Revised Codes
- ❑ 48 Deleted Codes
- ❑ New Modifiers

2022

Medicare Physicians Final Rule

Conversion Factors

	2022	2021
Physician Fee Schedule Conversion Factor	$34.6062 **CUT AVERTED**	$34.8932
Anesthesia Conversion Factor	$20.9343 **CUT AVERTED**	$21.5600

Senate and House Bill - December 2021

- ❑ Delays 2% cuts to Medicare through March 2022
- ❑ Delay sequestration 4% cuts to 2023
- ❑ Reduction in MPFS changed to a 0.75% reduction

CMS has re-calculate CF based on this

Cuts	Phase 1 Jan - March 2022	Phase 2 April - June 2022	Phase 3 July - Dec. 2022
Medicare Physician CF Reduction	0.82%	0.82%	0.82%
Medicare Sequestration	0%	1%	2%
PAYGO Sequestration	0%	0%	0%
Total Cuts Across the Board	0.82%	1.82%	2.82%

Medicare Part B Deductible - 2022

$170.10 (increase of $21.60 from 2021)

Final Rule Highlights for Your Physician Practice

- ❑ E/M Visits
  - ❑ Split (or shared) E/M Visits
  - ❑ Critical Care Services
  - ❑ Teaching Physician Services
  - ❑ Telehealth Services
  - ❑ New Modifiers
- ❑ Billing for PA Services
- ❑ Billing for PTAs and OTAs
- ❑ Vaccine Admin. Rates
- ❑ AUC Program to begin (in the future)

Split or Shared E/M Services

Definition:

*E/M services performed jointly by a physician and non-physician practitioner in a **facility setting** (outpatient department, inpatient, emergency department, skilled nursing facility).*

- ❑ Prior to 2021, shared services were a Medicare concept
- ❑ For Medicare payment differential for services billed by physicians and NPPs

Added to CPT in 2021

- In 2021, the AMA added the concept of shared services between a physician and qualified health care professional (QHP)
  - CMS uses the tern non-physician practitioner (NPP)
  - Both QHP and NPP mean someone who has E/M in their scope of practice

- Allows for E/M services to be jointly performed by a physician and NPP

CMS Rule changes for 2022

In May 2021, CMS removed instructions for shared services, critical care and nursing home services from the Medicare Claims Processing Manual, saying they would address the issue in rulemaking.

Split/shred in 2022 per Final Rule:

- Allowed: in facility settings inpatient, outpatient, including OBS, ED
- Allowed: in nursing facility for visits not mandated to be done by a physician
  - Skilled Facility: Initial care and every other subsequent visit thereafter
  - Mandated visits may **not** be billed as split/shared visits
- Allowed: for critical care
- Removed: allowed in office setting if met incident-to requirements

Clinicians sharing the E/M must be in the same group, same specialty

Substantive Portion

CMS believes E/M services performed split shared should be reported by the clinician who does a "substantive portion" of the visit

- ❑ In 2023, will be based on time
- ❑ In 2022, a transitional year, may be based on time or key components
- ❑ Also allowing prolonged care to be reported as split/shared

New Modifier required – to identify split/shared services

- ❑ **FS**: Split(or shared) evaluation and management service

Face-to-Face and Non-Face-to-Face

- ❑ Services may include both face-to-face and non-face-to-face activities
- ❑ The documentation must identify the two clinicians who shared the visits
- ❑ The individual who performs the substantive portion of the visit (and bills for it) must sign and date the encounter

Documentation

Example one: NPP spends 20 minute with patient, physician spends 15 minutes

- ❑ Each Clinician should document time spent; Report under the NPP who spent >50% of the time

Example two: NPP and physician each see the patient. Physician documents MDM in its entirety

- ❑ Identify both clinicians. Physician should sign and date the record, document the MDM in its entirety; Report under Physician based on a key component

Critical Care

- ❑ Adopting CPT descriptions, parentheticals and prefatory language
- ❑ Allowing concurrent care in the same time period by practitioners of different specialties
- ❑ Allowing physicians and NPPs in the same group, same specialty to share critical care services
- ❑ The time of these clinicians may be combined to meet the first hour of critical and subsequent 30-minute increments
- ❑ Physicians and NPPs of a different specialty providing medically necessary, non-duplicative care also use 99291 and 99292

Critical Care

If service crosses midnight, follow CPT rule:

"some services measured in units other than days extend across calendar dates. When this occurs, a continuous service does not reset and create a first hour. However, any disruption in the service does create a new initial service. For example, if intravenous hydration (96390, 96361) is given from 11 pm to 2 am, 96360 would be reported once and 96361 twice. For continuous services that last beyond midnight (that is, over a range of dates), report the total units of time provided continuously."

CPT 2022 p. xviii

Critical Care and Separate E/M

- ❑ Allowing an E/M service on the same day as critical care if the E/M service took place prior to the patient becoming critically ill, and critical care is reported for an additional service later in the day

- ❑ Status of patient changes

- ❑ Two distinct episodes of care

More Critical Care

- Will continue to allow critical care to be paid when done by surgeon in the post-op period for a 10- or 90-day global period
  - Critical care must be unrelated to the anatomic side or general surgery procedure that was performed
  - Use the new modifier FT, not modifier 24
  - Do not use FT except in this situation even though it doesn't say "critical care"

FT: Unrelated evaluation and management (E/M) visit during a postoperative period, or on the same day as a procedure or another E/M visit. (Report when an E/M visit is furnished within the global period but is unrelated or when one or more additional E/M visits furnished on the same day are unrelated).

Teaching Physician Rules

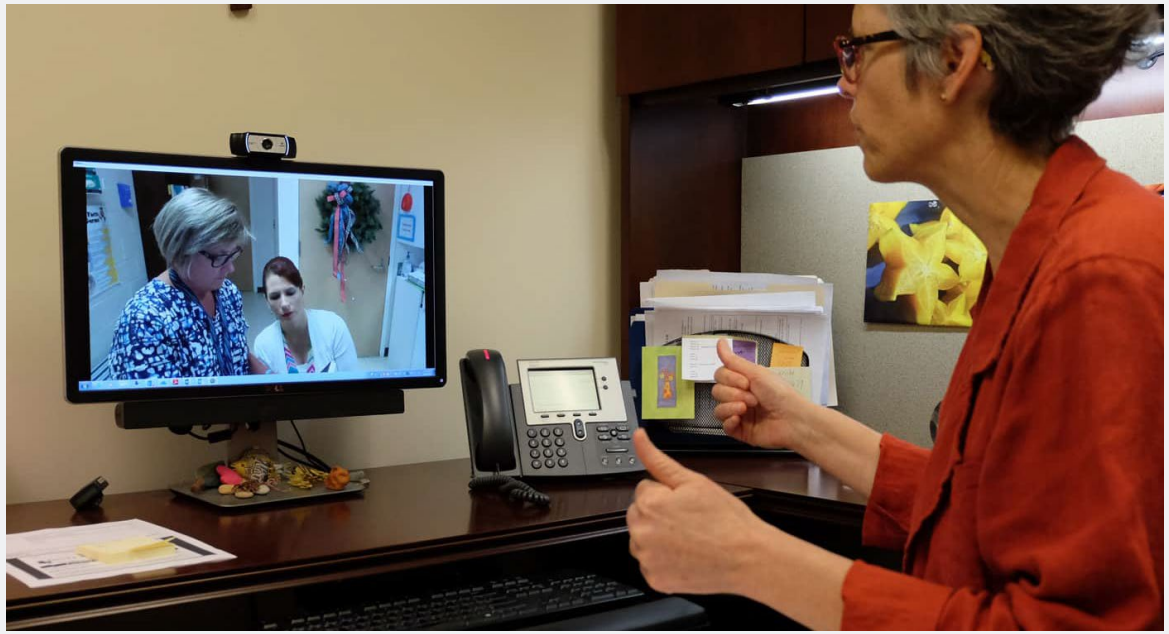
These appear to be clarifications, not policy changes

- ❑ If using time to select an E/M code, use only the time the attending is present: don't use resident time

From the rule, *"the so-called 'primary care exception . . ." p 472*

- During the PHE, clinicians billing under the primary care exception can report level 4 and 5 services, but when the PHE ends, would no longer be able to report level 4 and 5 E/M

Telehealth – What is Telehealth?



- CMS notes that the term is used broadly to refer to medical services furnished via telecommunications technology

- CMS uses the phrase "Medicare Telehealth Services: to refer to subset of services that are on its list, and may be billed via interactive, audio and visual communication

- CMS list of covered telehealth services during the PHE:

https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

Medicare Telehealth

1. Category 1 = similar to services already on the telehealth list – these are considered permanent

2. Category 2 – includes services that are not similar to services already on the list

3. Category 3 – telehealth services covered only through the calendar year the PHE ends

Telehealth and Office Visits

- The waivers that allowed practices to have telehealth visits when the patient was at home, regardless of geography will expire when the PHE ends
- The Secretary of Health and Human Services determines the end of the PHE, and coverage for office visits ends at that time
- Many groups lobbying Congress for action

Finalized: Any service added under Category 3 would remain on the list until December 31, 2023

What's on the Category 3 List?

- Biofeedback
- Neurological and psychological testing
- Therapy procedures
- Physical therapy evaluations
- Therapy procedures
- Therapy personal care
- Therapy tests and measurements
- Personal Care
- Evaluative and therapeutic services

Telephone Calls (Clinicians with E/M Scope of Practice

- Phone Codes 99441 – 99443
  - After the PHE, CMS is not proposing to continue payment for these codes because they are unable to waive the requirement that telehealth services be furnished via interactive, audio-visual communication after the end of the pandemic
  - Will return to non-covered status, decreased RVUs

Telehealth & Behavioral Health

- Consolidated Appropriations Act, 2021, allows telehealth for behavioral health services after the PHE ends
  - Would require a face-to-face visit within 6 months before for patient at home
  - Phone-only allowed ***only if*** the provider has the capacity for real-time, audio-visual communication but patient is unable or unwilling
  - Requires an in-person visit once every 12 months unless that would be "inadvisable or impractical" for the beneficiary
    - Limited exceptions: if so, document in the medical record

Audio-only Modifier

Audio-only modifier: FQ – audio-only service

Long description: The service was furnished using audio-only communication technology

- From the rule: *"in the interests of monitoring utilization and program integrity concerns for audio-only telehealth services furnished under the terms of this exception, we proposed to create a service-level modifier that would identify these mental health telehealth services furnished to a beneficiary in their home using audio-only communications technology: page 173*

- CMS is using this modifier to identify **mental health services furnished to a beneficiary in their home, phone only**
  - **Don't use the new FQ modifier for non-mental health E/M services performed audio only**

Physician Assistant Services (PA)

- The Consolidated Appropriations Act, passed December 27, 2020, removed requirement that payment for PA services could only go to employer of PA

- Staring January 1, 2022, Medicare can make direct payments to physician assistants

You Must STILL follow State Law!

Administration of Preventive Vaccines

- 1/1/2022 will pay $30 per dose for influenza, pneumococcal and hepatitis virus vaccines
- 1/1/2022 will maintain the current rate of $40 per dose for the administration of COVID-19 vaccines through the end of the calendar year in which the ongoing PHE ends.
  - Effective 1/1 of the year following the year in which the PHE ends, the payment rate for COVID-19 vaccine administration will be set at a rate to align with the payment rate for the administration of other Part B preventive vaccines

Payment for PT and OT furnished by Assistants (PTAs or OTAs)

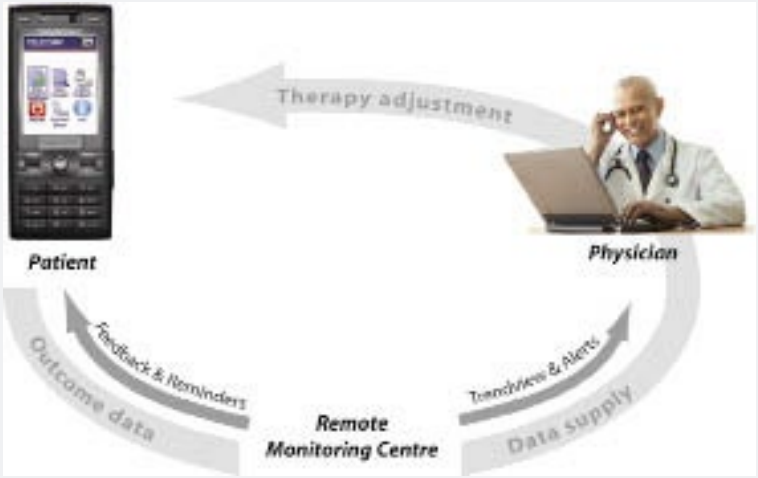
- Modifier CQ and CO identify these services, and reduce payment to 85%

- Allows a 15-minute timed service to be billed without modifiers in cases when PTA/OTA participates in the care, but the PT/OT meets Medicare requirement of reaching the midpoint on their own (9 minutes of 15-minute service)

Remote Therapeutic Monitoring and Treatment Management Services (RTM)

- Two sets of codes in the medicine section of CPT
- Code structure corresponds to codes in remote physiologic monitoring in the E/M section
- First set is for set up of equipment and education and device supply and monitoring for a 30-day period
- Second set is for professional management in a calendar month

What is RTM?



- Review and monitoring of data related to signs, symptoms and functions of a therapeutic response
- Data may be objective device generated, integrated data, or subjective inputs by patient
- Data are reflective of a therapeutic response that provide a functionally integrative representation of patient response

Remote physiologic monitoring (RPM)	Remote therapeutic monitoring (RTM)
99453, 99454 for device, set up and education and monitoring	98975, 98976, 98977 for device, set up and education and monitoring
99457, 99458 for treatment management services	98980, 98981 for treatment management services
Physiologic measures	Non-physiologic measures
Considered E/M services, may be reported by physicians, NPs, and PAs	May be reported by physicians, NPs, PAs and physical therapist and others
Clinical staff may bill incident to physician and NPP services for codes that are not physician/NPP treatment work	Services may not be billed incident to a physical therapist; may be billed by a PT/OT or PT / OT assistant, supervised by PT/OT
Data must be digitally uploaded	Data may be patient reported or digitally uploaded

98975, 98976, 98977 (summary)

- ❑ Must be ordered by a physician or NPP
- ❑ Use 98975 for the set up and patient education
- ❑ 98976 and 98977 may be used to report supply of the device for scheduled (daily) recordings and/or programmed alerts/transmission
- ❑ 98976 and 98977 are not used if less than 16 days of data in 30-day period

RTM Summary

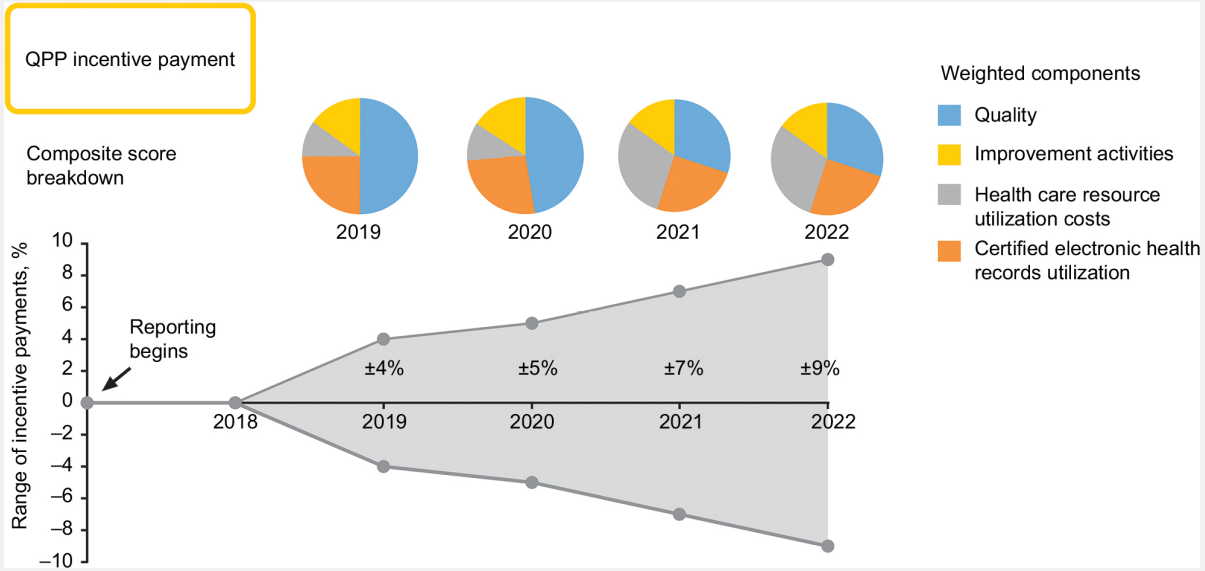
- ❑ Services must be ordered by a physician/NPP
- ❑ A physician or other qualified health care professional uses the results
- ❑ Do not use if a more specific CPT code exists
- ❑ Don’t double count time
- ❑ 98980 and 98981 require at least one interactive communication with patient or caregiver, which contributes to the time
- ❑ CPT book has a long list of codes “do not count time on day when” another service is done

Other Provisions of Final Rule

- Penalty phase for Appropriate Use Criteria (AUC) will not take effect until the later of 1/1/23 or the January 1st that follows the end of the PHE
- Expands coverage for pulmonary rehab to patients who had COVID
- Co-insurance for planned colorectal screening services that become diagnostic or therapeutic will be phased out to 0 between 2023 and 2030; remains 20% in 2022
- Allows a patient who is enrolling in hospice to elect a physician/NP/PA from an RHC or FQHC beginning in 2022

MIPS

- ✓ It's Part of the Final Rule
- ✓ It's Your Opportunity to raise your Medicare revenue
- ✓ There are changes



Timeline on Payment Adjustments

	2016	2017	2018	2019	2020	2021	2022	2023	2024	2025	2026 on
Fee Schedule Updates	0.5% annual baseline updates ⟷				No annual baseline updates ⟷						0.25% or 0.75%
MIPS	Max Adjustment (additional bonuses possible)			4% ↑↓	5% ↑↓	7% ↑↓	9% ↑↓	9% ↑↓	9% ↑↓	9% ↑↓	
QPs in Adv. APMs				5% bonus ⟷							

MIPS Eligibility – Low Volume Threshold

Medicare Part B Allowed Charges

- < $90,000
- Check your EOBs

Medicare Part B Patients

- <200
- Run report – patient by payer

Medicare Part B Services

- <200
- Run report – CPT code by payer

Opt-In Policy if only one or two thresholds are met

MIPS Eligible Clinicians

- ❑ Physicians
  - ❑ MD
  - ❑ DO
  - ❑ DDS
  - ❑ DMD
  - ❑ DPM
  - ❑ OD
- ❑ Chiropractor (DC)
- ❑ Physician Assistant (PA)
- ❑ Nurse Practitioner (NP)
- ❑ Clinical Nurse Specialist (CNS)
- ❑ Certified Nurse Anesthetist (CRNA)
- ❑ PT/OT
- ❑ SLP
- ❑ Qualified Audiologist
- ❑ Clinical Psychologist
- ❑ Clinical Social Worker (LCSW) **(new 2022)**
- ❑ Certified Nurse Midwife (CMN) **(new 2022)**

Reporting Options

- Individual
- Group
- Virtual Group
- MIPS APM

Quality = 30% (down 15 from 45%)

Promoting Interoperability = 25%

Improvement Activities = 15%

Cost = 30% (up 15 from 15%)

Category Weights for 2022 (100 Possible Final Score Points)

Update to Performance Threshold

- Bipartisan Budget Act of 2018 requires a "gradual and incremental transition" for raising the performance threshold during the first 5 years of the MIPS program
- Beginning in year 6 (PY 2022) performance threshold must be the "mean or medial of the composite performance scores for all MIPS eligible professionals" from a prior year
- Uses the man final score from the 2017 performance year/2019 MIPS payment year

75 points Must earn 75 total points to avoid negative adjustment (60 in 2021)

Small Practice Considerations

- ✓ CMS has implemented several new policies designed to offer additional assistance and flexibilities to small practices
- ✓ Automatically reweighting the Promoting Interoperability performance category to 0%
- ✓ If PI performance category is reweighted
  - ✓ Quality = 40%
  - ✓ Cost = 30%
  - ✓ IA = 30%
- ✓ If both PI and Cost performance categories are reweighted
  - ✓ Quality = 50%
  - ✓ IA = 50%
- ✓ When both the Quality and PI performance categories are reweighted
  - ✓ Cost = 50%
  - ✓ IA = 50%
  - ✓ Applies to all MIPS participants regardless of small practice status

Quality Reporting Requirements

- ❑ Report six individual measures or a complete specialty measure set
- ❑ At least one Outcome Measure **or** one High-Priority Measure
  - ❑ If an outcome measure is available, you **must** report it, or you will receive 0 points for that measure
- ❑ If fewer than six measures apply to our specialty, submit all that apply (subject to EMA)
- ❑ Available collection types for groups, virtual groups, and APM entities reporting traditional MIPS for the 2022 Performance Period
  - ❑ Electronic Clinical Quality Measures (eCQMs)
  - ❑ Medical Part B Claims Measures (**small practices only)**
  - ❑ MIPS Clinical Quality Measures (MIPS CQMs)
  - ❑ QCDR Measures
  - ❑ CMS Web Interface Measures **(new for 2022 – for groups only)**

Measure Updates – Additions and Changes

- ❑ 200 quality measures available for 2022 performance year
- ❑ 87 measures had substantive changes
- ❑ One new specialty measure set for Certified Nurse Midwives
- ❑ Three new quality measures
- ❑ One new administrative claim measure

Improvement Activities

- Must perform the same improvement activity for at least a consecutive 90-day period
  - Document who participated
  - Documentation is important
    - CMS audits ALL data!
    - They can (and do) take away money!
- Must earn total of 40 points
  - 2 high weighted activities (20 pts each)
  - 1 high-weighted (20 pts) and 2 medium-weight activities (10 pts each)
  - 4 medium-weighted activities (10 pts each)
- Activity weight doubles for qualifying special statuses
- At least **50%** of the clinicians in a group must perform the same improvement activity during the selected reporting period

IA Measure Updates

- ❑ 7 New Activities
- ❑ 6 Deleted Activities
- ❑ 15 Modified Activities

Cost Performance Category

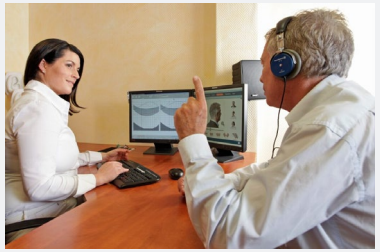
- CMS uses Medicare claims data to calculate cost measure performance, which means clinicians don't have to submit any data for this performance category
- Added 5 new episode-based cost measures

Measure Name	Measure Type	Case Minimum
Melanoma Resection	Procedural	10 episodes
Colon and Rectal Resection	Procedural	20 episodes
Sepsis	Acute Inpatient	20 episodes
Diabetes	Chronic Condition	20 episodes
Asthma/COPD	Chronic Condition	20 episodes

Promoting Interoperability (reweighting)

PI performance category will be automatically reweighted for the following clinician types

- NP
- PA
- CRNA
- CNS
- PT
- OT
- SLP
- Audiologists
- Clinical Psychologists
- Dieticians
- LCSW (new 2022)
- Small practices (new 2022)



Promoting Interoperability Requirements

- ❑ Requires use of a Certified Electronic Health Record (CEHRT) that meets the 2015 Edition certification criteria
  - ❑ Must be used for entire performance period
  - ❑ Must provide ONCD-ACB CEHRT Certification ID Number

  (https://chpi.healthit.gov/#/search)
- ❑ Must perform or review a Security Risk Analysis within the calendar year
- ❑ Answer "yes" to the Prevention of Information Blocking (modified) and ONC Direct Review attestations
- ❑ Report on the required measures **or** claim their exclusions

PI Objective and Measure Changes

- Public Health and Clinical Data Exchange Objective
  - Modified the reporting requirements and added a new exclusion
  - MIPS eligible clinicians now required to report the following 2 measures
    - Immunization Registry Reporting
    - Electronic Care Reporting
  - Following Measures are Optional
    - Public Health Registry Reporting measure
    - Clinical Data Registry Reporting measure
    - Syndromic Surveillance Reporting measure
  - Reporting a "yes" on any measure will earn 5 bonus points total (no more than 5 bonus pts)
- Added a new measure – Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)
  - MIPS eligible clinicians must attest to conducting an annual assessment of the High Priority Guide of the Safety Assurance Factors for EHR Resilience Guides (SAFER Guides)

Thanks for Your Attention;

For More Questions

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References

- Errata and Technical Corrections – CPT 2022 (from 12/30/21):

  https://ama-assn.org/system/files/cpt-corrections-errata-2022.pdf

- CPT errata & technical corrections page: https://www.ama-assn.org/practice-management/cpt/cpt-errata-technical-corrections
- 2022 PFS Final Rule with Updated RVU amounts: https://www.cms.gov/files/zip/cy-2022-pfs-final-rule-addenda.zip
- 2022 Anesthesia Base Units (for RVUs): https://www.cms.gov/files/zip/2022-anesthesia-base-units-cpt-code.zip
- Updated COVID-19 Vaccine and Monoclonal Antibody Treatment codes here: https://www.cms.gov/medicare/medicare-part-b-drug-average-sales-price/covid-19-vaccines-and-monoclonal-antibodies

References

- PY 2022 QPP Final Rule Resources

https://www.qpp.cms.gov

- Great MVP resources

https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1654/2022%20Quality%20Payment%20Program%20Final%20Rule%20Resources.zip

- Cost performance category User Guide:

https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1433/2021%20MIPS%20Cost%20User%20Guide.pdf

- Guidance on conducting Security Risk Analysis: https://www.hhs.gov/hipaa/for-professionals/security/guidance/guidance-risk-analysis/index.html?language=es