
MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.
Date: November 4, 2021
Re: Summary of the 2022 Medicare Final Payment Rules: Physician Fee Schedule;
Outpatient Prospective Payment System; and Ambulatory Surgical Centers

On November 2, 2021, the Centers for Medicare & Medicaid Services (CMS) released both the CY 2022 Medicare Physician Fee Schedule (PFS) final rule and the CY 2022 Medicare Hospital Outpatient Prospective Payment System and Ambulatory Surgical Center Payment System (OPPS & ASC) final rule. The following is a summary of policies in the final rules that may affect AAHKS members.

See the last page for a table summarizing Medicare rates in 2022.

PHYSICIAN FEE SCHEDULE

Conversion Factor

- CMS finalizes a PFS conversion factor of **\$33.59** a \$1.30 decrease from the 2021 conversion factor of \$34.89—to reflect the budget neutrality adjustment that accounts for changes in relative value units (RVUs) and the expiration of the one-time 3.75% payment increase Congress provided through the Consolidated Appropriations Act, 2021.
- CMS emphasized it lacks legal authority to reduce or delay this statutorily required reduction.

2023 Implementation of MIPS Value Pathways (MVPs)

- CMS will begin implementing the Medicare Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) in 2023. MVPs are intended to “simplify the MIPS clinician experience, improve value, reduce burden, and better inform patient choice in selecting clinicians”. This 2023 timeframe is intended to provide practices the time to review requirements, update workflows, and prepare their systems as needed to report MVPs.
- For the 2023 and 2024 performance years, required “MVP Participants” will mean:
 - individual clinicians,

- single specialty groups,
 - multispecialty groups,
 - subgroups, and
 - APM entities that are assessed on an MVP for all MIPS performance categories.
- MVP reporting will be optional for 2023. CMS is delaying until 2026 the requirement that multispecialty groups form subgroups in order to report MVPs.

Final Improving Care for Lower Extremity Joint Repair MVP

- Quality Measures
 - Q350: Total Knee Replacement: Shared Decision-Making: Trial of Conservative (Non-surgical) Therapy
 - Q351: Total Knee Replacement: Venous Thromboembolic and Cardiovascular Risk Evaluation
 - Q376: Functional Status Assessment for Total Hip Replacement
 - Q470: Functional Status After Primacy Total Knee Replacement
 - Q480: Risk-standardized complication rate (RSCR) following elective primary THA and/or TKA
 - Q128: Preventive Care and Screening: BMI Screening and Follow-Up Plan
 - CCOME6: Patient-Reported Pain and/or Function Improvement after APM Surgery and CCOME7: Patient-Reported Pain and/or Function Improvement after THA were considered but not included
- CMS is adding Q024: *Communication with the Physician or Other Clinician Managing On-Going Care Post-Fracture for Men and Women Aged 50 Years and Older within this MVP*. During MVP development, however, commenters convinced CMS that the MVP as proposed did not consider the care gap patients suffer in post-acute follow-up to address the chronic underlying bone loss that increases risk of future fractures and associated morbidity, mortality, and costs. CMS' agreed that ensuring care coordination for the treatment of osteoporosis is important for this patient population.
- Improvement Activities
 - IA CC 15: PSH Care Coordination: Contributes to the coordinated care of the patient required after a procedure such as a hip/knee replacement. The Perioperative Surgical Home (PSH) strives to provide the patient with the "right care, in the right place, at the right time" to ensure patient satisfaction while reducing complications and costs.
 - IA PSP A 27: Invasive Procedure or Surgery Anticoagulation Medication Management: To address blood-clotting issues commonly associated with hip/knee replacement. Statistical data indicates that hip and knee replacements are a commonly performed inpatient procedure with long recovery times that often incur sizable expenses in terms of hospitalization and rehabilitation.
 - IA_AHE_3: Promote use of Patient-Reported Outcome Tools

- IA_BE_6: Collection and follow-up on patient experience and satisfaction data on beneficiary engagement
 - IA_BE_12: Use evidence-based decision aids to support shared decision-making
 - IA_CC_7: Regular training in care coordination
 - IA_CC_9: Implementation of practices/processes for developing regular individual care plans
 - IA_CC_13: Practice improvements for bilateral exchange of patient information
 - IA_PSPA_6: Consultation of the Prescription Drug Monitoring Program
 - IA_PSPA_7: Use of QCDR data for ongoing practice assessment and improvements
 - IA_PSPA_18: Measurement and improvement at the practice and panel level
- Cost Measures - Elective Primary Hip Arthroplasty and Knee Arthroplasty episode-based measures.

Quality Payment Program Changes in 2022 – Facility Affiliations

- For HHS' Public Reporting on Compare Tools, CMS will publicly report clinician affiliations to certain types of facilities (for example, LTCHs, IRFs, etc.).

Changes to the Requirements for Electronic Prescribing for Controlled Substances for a Covered Part D Drug under a Prescription Drug Plan or an MA-PD Plan

- CMS finalized some exceptions to the electronic prescribing of controlled substances (EPCS) requirement for schedule II, III, IV, and V controlled substances set forth in the SUPPORT Act. These exceptions would apply (1) when the prescriber and dispensing pharmacy are the same entity; (2) to prescribers who issue 100 or fewer controlled substance prescriptions for Part D drugs per calendar year; and (3) to prescribers who are in the geographic area of a natural disaster, or who are granted a waiver based on extraordinary circumstances. CMS is delaying the start date for compliance to January 1, 2023.

-continued-

OUTPATIENT PROSPECTIVE PAYMENT SYSTEM & AMBULATORY SURGICAL CENTER PAYMENT SYSTEM

Preservation of the Medicare Inpatient Only (IPO) List

- CMS decided that it prefers CMS to remove procedures from the IPO based on procedure-specific review based on nomination as opposed to removing whole classes of procedures in bulk. Therefore, CMS is finalizing its proposal to preserve the IPO and return the musculoskeletal-related CPT codes previously removed in 2021 to the IPO list, including
 - 27702 (Arthroplasty, ankle; with implant [total ankle]); 27703 (Arthroplasty, ankle; revision, total ankle); 27445 (Arthroplasty, knee, hinge prosthesis [for example, walldius type]); 27487 (Revision of total knee arthroplasty, with or without allograft; femoral and entire tibial component); 27488 (Removal of prosthesis, including total knee prosthesis, methylmethacrylate with or without insertion of spacer, knee); 27125 (Hemiarthroplasty, hip, partial [for example, femoral stem prosthesis, bipolar arthroplasty]); 27132 (Conversion of previous hip surgery to total hip with or without autograft or allograft); 27134 (Revision of total hip arthroplasty; both components, with or without autograft or allograft); 27137 (Revision of total hip arthroplasty; acetabular component only, with or without autograft or allograft); 27138 (Revision of total hip arthroplasty; femoral component only, with or without allograft); and 27140 (Osteotomy and transfer of greater trochanter of femur [separate procedure]).
- TKA and THA will remain *off the IPO list* and available for outpatient reimbursement because these procedures were earlier removed from the IPO list on an individualized review.
- In preserving the IPO, CMS cited many of the arguments from AAHKS around the problematic interface with the 2-midnight rule for procedures newly available for outpatient status.
 - CMS states: *“It is a misinterpretation of CMS payment policy for providers to create policies or guidelines that establish the hospital outpatient setting as the baseline or default site of service for a procedure based on its removal from the IPO list. As stated in previous rulemaking, services that are no longer included on the IPO list are payable in either the inpatient or hospital outpatient setting subject to the general coverage rules requiring that any procedure be reasonable and necessary, and payment should be made pursuant to the otherwise applicable payment policies.”*
 - CMS states: *“We continue to believe that physicians should use their complex clinical judgment, together with consideration of the beneficiary’s needs, to*

determine the appropriate site of service. We continue to strive to balance the goals of increasing physician and patient choice of setting of care with consideration of patient safety for all Medicare beneficiaries.”

Interaction between Inpatient Hospital Admissions and the 2-Midnight Rule

- CMS is finalizing a new policy whereby procedures that are removed from the IPO list on or after January 1, 2021 are exempt from the following reviews for 2 years:
 - Site-of-service claim denials
 - Beneficiary and Family-Centered Care Quality Improvement Organization (BFCC-QIO) referrals to Recovery Audit Contractor (RAC) for persistent noncompliance with the 2-midnight rule, and
 - RAC reviews for “patient status” (site-of-service)
- THA and TKA are no longer exempt from these types of reviews because they were removed from the IPO more than 2 years ago.
- CMS states it plans to develop new stakeholder education materials to support physician-decision making for procedures that are removed from the IPO list in the future.

Contraction of the List of ASC Covered Surgical Procedures

- CMS is finalizing its proposal to reverse last year’s decision to add 267 surgery/surgery-like codes to the ASC CPL. Instead, CMS will return to its earlier policy of evaluating individual procedures for possible exclusion. In early 2022, CMS will release new subregulatory guidance describing the process to nominate a procedure to be added to the CPL.
- TKA and THA will remain on the ASC CPL because these procedures were earlier added to the CPL based on individualized review.

Adding a Patient-Reported Outcomes Measure (PROM) Following Elective THA or TKA

- CMS earlier sought input on the potential future development and inclusion of a PROM following elective outpatient THA/TKA as a hospital quality measure. CMS previously established the voluntary PRO data collection opportunity under the Comprehensive Care for Joint Replacement (CJR) model and developed the Hospital-Level, Risk-Standardized Patient-Reported Outcomes Following Elective Primary THA/TKA performance measure (THA/TKA PRO-PM)¹ to be submitted by participating hospitals. CMS subsequently updated the measure based on stakeholder feedback.

¹ NQF ID # 3559; CMIT ID # 3198.

- AAHKS provided feedback on how such a PROM could fit into the Hospital Outpatient Quality Reporting System. CMS acknowledged AAHKS comments that a THA/TKA PRO-PM would require providers to collect pre- and post-operative data for at least 25 cases to ensure a reliable measure score.
- CMS states: *“We will continue to monitor the number of THA and TKA procedures in the outpatient setting and when we believe there is a sufficient number of such procedures performed in these settings to reliably measure a meaningful number of facilities, we may consider expanding the PRO-PM to these settings.”*

Increased Penalties for Failure to Make Hospital Standard Charges Transparent

- CMS earlier implemented a policy requiring hospitals to make public their standard charges (both gross charges and payer-specific negotiated charges) for all items and services online in a machine-readable format.
- CMS is finalizing an increase monetary penalties, scaled for size, for hospitals in violation of the new price-transparency requirements.
 - For a hospital with 30 or fewer beds, the maximum daily dollar civil monetary penalty amount to which it may be subject is \$300
 - For a hospital with at least 31 and up to and including 550 beds, the maximum daily dollar civil monetary penalty amount to which it may be subject is the number of beds times \$10
 - For a hospital with a number of beds greater than 550, the maximum daily dollar civil monetary penalty amount to which it may be subject is \$5,500.

-continued-

Medicare Payment Trends for Hip and Knee Surgeries in the United States

Code (DRG/CPT)	2018		2019		2020		2021		2022		% Change from 2021
	Weight	Rate	Weight	Rate	Weight	Rate	Weight	Rate	Weight	Rate	
IPPS^{1, 2}											
469	3.201	\$17,837.66	3.1742	\$17,921.78	3.1399	\$18,200.84	3.0989	\$18,530.61	3.0866	\$18,952.62	+2.3%
470	2.0543	\$11,447.64	1.9898	\$11,234.56	1.9684	\$11,410.09	1.9104	\$11,423.69	1.9015	\$11,675.76	+2.2%
521	--	--	--	--	--	--	3.0652	\$18,329.99	3.0663	\$18,827.97	+2.7%
522	--	--	--	--	--	--	2.1943	\$13,121.34	2.1903	\$13,449.08	+2.5%
OPPS											
27130	--	--	--	--	147.2988	\$11,899.38	148.7344	\$12,314.76	149.6049	\$12,593.29	+2.3%
27447	128.7225	\$10,122.22	134.7827	\$10,713.88	147.2988	\$11,899.38	148.7344	\$12,314.76	149.6049	\$12,593.29	+2.3%
ASC											
27130	--	--	--	--	--	--	180.4429	\$8,833.04	180.8564	\$9,027.63	+2.2%
27447	--	--	--	--	180.3081	\$8,609.17	179.2409	\$8,774.20	179.6492	\$8,967.37	+2.2%
27429*	111.2415	\$5,069.83	151.2694	\$7,041.74	224.0958	\$10,717.80	211.7260	\$10,364.41	212.2784	\$10,596.09	+2.2%
PFS											
27130 ³	35.9996	\$1,409.74	36.039	\$1,408.77	36.0896	\$1,415.07	34.8931 ⁴	\$1,322.45	33.5983	\$1,277.40	-3.4%
27447 ⁵	35.9996	\$1,408.30	36.039	\$1,408.05	36.0896	\$1,413.27	34.8931 ⁶	\$1,320.70	33.5983	\$1,276.06	-3.4%

¹ **National Payment Amount** – Projected by CMS of the baseline amount that will be paid nationally for the MS-DRG. This amount **DOES NOT INCLUDE** facility-specific calculation of teaching, disproportionate share, capital, and outlier payments for all cases. See footnote 2.

² Assumes hospital reported quality data and is a meaningful EHR user.

³ **Total RVUs** – 2020 (39.21); 2021 (37.88); 2022 (38.06)

⁴ **2021 Final PFS Conversion Factor** – Conversion factor (CF) reduction required by statutory budget neutrality adjustment law. Partially offset by CF increase based on (1) one-time 3.75% increase for 2021, and (2) delayed implementation of the inherent complexity add-on code for e/m services (G2211).

⁵ **Total RVUs**: 2020 (39.16); 2021 (37.83); 2022 (38.02)

⁶ **2021 Final PFS Conversion Factor** – CF reduction required by statutory budget neutrality adjustment law. Partially offset by CF increase based on (1) one-time 3.75% increase for 2021, and (2) delayed implementation of the inherent complexity add-on code for e/m services (G2211).

* For comparison purposes with newly covered outpatient procedures, the CPT code for Reconstruction Knee is included