



ACR Preliminary Summary of Radiology Provisions in the 2022 MPFS Final Rule

The Centers for Medicaid and Medicare Services (CMS) released the calendar year (CY) 2022 Medicare Physician Fee Schedule (MPFS) final rule on November 2nd. In this rule, CMS describes changes to payment provisions and to policies for implementation for the Quality Payment Program (QPP) and its component participation methods – the Merit-Based Incentives Payment System (MIPS) and Advanced Alternative Payment Model (APMs).

Appropriate Use Criteria (AUC)/ Clinical Decision Support (CDS)

The ACR is pleased with CMS’s decision to move forward with the appropriate use criteria (AUC) program for advanced diagnostic imaging services mandated by the Patient Access to Medicare Act of 2014 with the penalty phase to begin on January 1, 2023, or the first of the year following the end of the COVID-19 public health emergency (PHE). CMS recognizes the significant hardships faced by hospitals and medical practices during the pandemic as well as the investment that many practices have already made in AUC systems. When fully implemented, the AUC program will be a valuable tool to ensure that Medicare patients receive the right imaging at the right time. The final rule also includes several solutions to claims processing issues that have delayed the program’s implementation. CMS indicates in the final rule that they will use the time between now and the beginning of the penalty phase of the AUC program to continue provider education efforts to ensure that all ordering professionals are aware of the consultation requirements and the information that must be delivered to imaging providers with advanced diagnostic imaging orders.

Conversion Factor and CMS Overall Impact Estimates

The CY 2022 conversion factor will be \$33.5983 compared to the 2021 conversion factor of \$34.8931. CMS estimates an overall impact of the MPFS changes to radiology to be a 1 percent decrease, while interventional radiology would see an aggregate decrease of 5 percent, nuclear medicine a 1 percent decrease and radiation oncology and radiation therapy centers a 1 percent decrease. Part of the decrease is due changes in RVUs, redistributive effects of the CMS proposed clinical labor pricing update, and phase-in implementation of the previously finalized updates to supply and equipment pricing.

The Consolidated Appropriations Act, 2021 (P.L.116-260) included a 3.75 percent adjustment to the 2021 conversion factor which rolled back the payment cuts to radiologists. If Congress does not intervene, the percent decreases mentioned above could be greater for CY 2022 for many physicians including radiology.

Clinical Labor Update

The ACR is disappointed that CMS chose to move forward with the 4-year implementation of the clinical labor pricing updates, beginning 2022 and ending in 2025. While sensitive to the PHE impacts on specialties, CMS feels that it is important to implement the clinical pricing updates in order to maintain relativity within the practice expense, since equipment and supplies inputs will be fully transitioned in 2022. However, due to the work of the ACR and the Clinical Labor Coalition, CMS has made some revisions to their initial proposed methodology:



- CMS will apply the 2019 fringe benefits multiplier instead of using the 2002 benefits multiplier.
- CMS will use the BLS median wage data instead of the mean wage data.
- CMS has made some updates or adjustments to some of the proposed clinical labor wage crosswalks, including the medical physicist, mammography technologist, and angio technician.

These changes are anticipated to decrease the initial estimated impact to radiology from -2 to -1 percent, -2 to -1 percent for nuclear medicine, -9 to -5 percent for interventional radiology, and -5 to -1 percent radiation oncology and radiation therapy centers.

CMS states that the clinical labor rates will remain open for public comment over the course of the 4-year transition period. They welcome additional feedback on clinical labor pricing from commenters in next year's rulemaking cycle, especially any data that will continue to improve the accuracy of their finalized pricing.

Billing for Physician Assistant (PA) Services

Historically, NPs and CNSs have been authorized to bill the Medicare program and be paid directly for their professional services, while payment for PAs services must be made to the PA's employer. The Consolidated Appropriations Act (CAA) of 2021 made amendments to remove the requirement to make payment for PA services only to the employer of a PA effective January 1, 2022. With the removal of this requirement, PAs will be authorized to bill the Medicare program and be paid directly for their services in the same way that NPs and CNSs do. CMS is implementing section 403 of the CAA, which authorizes Medicare to make direct payment to PAs for professional services that they furnish under Part B beginning January 1, 2022. Medicare currently can only make payment to the employer or independent contractor of a PA. Beginning January 1, 2022, PAs may bill Medicare directly for their professional services, reassign payment for their professional services, and incorporate with other PAs and bill Medicare for PA services

Valuation of Services

In the MPFS 2022 Final Rule, CMS finalized their proposal to accept all of the RUC-recommended values for 5 new/revised codes impacting Radiology. CMS accepted an increased value for needle biopsy of lymph nodes and approved the values for the new, trabecular bone score code family. The ACR will continue to review the final rule, including any practice expense refinements.

Artificial Intelligence (AI) / Innovative Technologies

In the MPFS 2022 Final Rule, CMS proposed to establish values for CPT code 92229 (remote retinal imaging) with a crosswalk methodology and will forego making it contractor-priced as originally stated in the MPFS 2021 Final Rule. The Agency proposed to crosswalk CPT code 92229 to CPT code 92325, a practice-expense-only code related to the eye. Additionally, CMS proposed to use the crosswalk approach for the Trabecular Bone Score (TBS) codes involving practice expense (CPT codes 77089 and 77091) based on a crosswalk to CPT code 71101 (x-ray of the ribs, minimum of 3 views) as a comparable service. The Agency recognized that there are



services which use innovative technologies (i.e., software algorithms and AI) such as the remote retinal imaging and TBS codes and notes that these types of services are not well accounted for in their PE methodology. CMS will continue to work with stakeholders to understand the resource costs which should be represented in greater depth.

Removal of Select National Coverage Determinations

CMS finalizing the proposal to remove the national coverage determination (NCD) for positron emission tomography (PET) scans (NCD 220.6). Removing the NCD will defer coverage decisions to local Medicare Administrative Contractors. The NCD for PET was last updated in 2013 and requires separate NCDs for every non-oncologic indication for PET scans. Since 2013, new non-oncologic PET agents have been approved by the FDA and multiple professional medical societies, including the ACR, have published guidelines relevant to appropriate use of these agents. Allowing local contractors the discretion to consider coverage will allow Medicare beneficiaries greater access to PET scans for non-oncologic indications.

Telehealth

Category 1 and Category 2 Telehealth Services

CMS received several requests to permanently add various services to the Medicare telehealth services list effective for CY 2022. However, CMS found that none of these services met the criteria for Category 1 or Category 2 services for permanent addition to the Medicare telehealth services list.

Category 3 Telehealth Services

In the CY 2021 MPFS final rule, CMS created a third category of criteria for adding services to the telehealth services list on a temporary basis in response to the COVID-19 public health emergency (PHE). Category 3 telehealth services include services which CMS believes there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence to be Category 1 or 2.

Services on the Category 3 telehealth list will be temporary and remain on the telehealth services list through the end of the calendar year in which the COVID-19 PHE ends. There have been stakeholder concerns surrounding uncertainty of when the PHE will end and concerns that services added to the telehealth services list on a temporary basis could be removed from the list before there is enough time to compile and submit evidence to support permanent addition of the service as a Category 1 or 2 service. In response, CMS will retain all Medicare services added on a Category 3 basis until the end of CY 2023, to allow more time to collect information on utilization of these services. CMS will facilitate the submission of requests to add services permanently to the Medicare telehealth services list for consideration in the CY 2023 PFS rulemaking process and for consideration in the CY 2024 PFS rule. CMS will also be adding CPT codes 93797 (Physician or other qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)) and 93798 (Physician or other qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)) and HCPCS codes G0422 (Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session) and



G0423 ((Intensive cardiac rehabilitation; with or without continuous ECG monitoring; without exercise, per session) to the Category 3 Medicare telehealth services list.

Audio-Only Telehealth Services

CMS is amending the current definition of interactive telecommunications system for telehealth services, which is defined as multimedia communications equipment that includes, at a minimum, audio and video equipment permitting two-way, real-time interactive communication between the patient and distant site physician or practitioner, 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.

CMS is limiting the use of an audio-only interactive telecommunications system to mental health services furnished by practitioners who have the capability to furnish two-way, audio/video communications, but where the beneficiary is not capable of, or does not consent to, the use of two-way, audio/video technology.

CMS also 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.

CMS has found that audio-only E/M visits have been one of the most performed telehealth services during the PHE, with most beneficiaries receiving mental health services. Given the mental health professional shortage and areas in which beneficiaries have limited broadband access due to geographic area or socioeconomic challenges, CMS believes beneficiaries may have come to rely on these audio-only mental health care services and that a sudden discontinuation could have a negative impact on access to care.

Quality Payment Program

MIPS Value Pathways (MVPs) (p. 1147)

CMS refined plans for the transition of MVPs into MIPS. Specifically, MVP implementation is delayed until the performance year (PY) 2023, maintaining that MVPs will be incrementally added to the QPP upon availability. Additionally, CMS finalized the seven MVPs that will become available beginning with the 2023 performance period. From PY 2023 until 2025, MVP Participants are identified as individual clinicians, single or multispecialty groups, or APM entities assessed on an MVP for all MIPS categories.

Beginning with PY 2026, multispecialty groups are required to form subgroups for reporting in MVPs. Further, starting with PY 2023, MVP Participants and subgroups must register to participate in a particular MVP. Once registered, CMS will assign a unique subgroup identifier, separate from the individual NPI (National Provider Identifier), group TIN (Taxpayer



Identification Numbers), and MVP identifiers. CMS also finalized MVP participation requirements.

Advancing to Digital Quality Measurement (dQM) and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs – Request for Information (RFI) (p. 1146)

CMS responded to comments regarding the RFI, issued within the Physician Fee Schedule proposed rule for 2022. As described in the proposed rule, the RFI is to aid CMS' transition to complete digital measurement by 2025. CMS did not finalize policy on the adoption of dQM in this rule. However, the comments from CMS reflect an ongoing effort to design a framework that promotes data interoperability and access.

Closing the Health Equity Gap in CMS Clinician Quality Programs – RFI (p. 1168)

Consistent with the executive order on Advancing Racial Equity and Support for Underserved Communities through the Federal Government, CMS issued this RFI within the Physician Fee Schedule proposed rule for 2022. CMS finalized the definition of a population health measure for MIPS as “a quality measure that indicates the quality of a population or cohort’s overall health and well-being (e.g., care access, clinical outcome, care coordination and community services, etc.) for working towards health equity for all patients.

COVID-19 Flexibility (p. 1588)

CMS anticipates that the national public health emergency (PHE) COVID-19 will continue to affect clinicians throughout the rest of PY 2021. CMS is allowing individual clinicians, clinician groups, and virtual groups to apply for [Extreme and Uncontrollable Circumstances](#) (EUC) to reweight one or more performance categories for PY 2021. If a clinician, clinician group or a virtual group submits an EUC application and also submits performance data for a category, the data will override the EUC application.

MIPS Category Weighting (p. 1577)

The final category weights for PY 2022 are: **Quality – 30 percent, Cost – 30 percent, PI – 25 percent, and IAs – 15 percent.**

The final rule continues to offer category reweighting for physicians who are unable to submit data for one or more performance categories. In most cases, the weight of these categories will continue to be redistributed to the Quality Performance category.

MIPS Performance Threshold and Incentive Payments (p. 1595)

The Bipartisan Budget Act of 2018 gave CMS the flexibility to set a performance threshold for three additional years (PY 2019-2021) so as to continue an incremental transition to the statutorily required performance threshold based on the mean or median of final scores from a prior period. **Beginning with PY 2022, CMS has finalized the performance threshold of 75 points, which represents the mean of PY 2017 data.**



The exceptional performance threshold has been finalized at 89 points, representing the 25th percentile of actual final scores above the performance threshold from PY 2017. This is the last year that the additional MIPS adjustment factors for exceptional performance will be available. In 2019, CMS finalized the payment adjustment of +/- 9% for PY 2020 and beyond.

Low-Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations (p. 1875)

To be excluded from MIPS in 2022, clinicians or groups would need to meet one of the following three criteria: have \leq \$90K in allowed charges for covered professional services, provide covered care to \leq 200 beneficiaries, or provide \leq 200 covered professional services under the Physician Fee Schedule. There are no changes to the opt-in policy established which allows physicians who meet some, but not all, of the low-volume threshold criteria to opt-in to participate in MIPS.

CMS is maintaining the small practice bonus of 6 points that is included in the Quality performance category score. CMS also continues to award small practices three points for submitted quality measures that do not meet case minimum requirements or do not have a benchmark.

In previous MIPS performance years, small practices had been allowed to submit Quality measure data via claims reporting rather than registry-based reporting. The 2022 Final Rule continues to allow claims submission for small practices but **will require that claims-reporting small practices who wish to submit MIPS data as a group must signal their intention to participate as a group by submitting either Improvement Activities, Promoting Interoperability measures, or MIPS CQMs as a group.** If they do not report another performance category as a group, they would be considered individual submitters.

Quality Performance Category (p. 1308)

As previously stated, CMS has lowered the weight of the Quality performance category. This category will be weighted at 30 percent for the PY 2022.

CMS has finalized several major changes to the measure scoring system. In previous years, non-benchmarked measures which met data completeness were eligible to receive three points, with the possibility of a higher score if enough data was received to establish a same-year benchmark. Benchmarking measures were scored between three and ten points if they met data completeness. **Beginning with PY 2023, CMS will remove the three-point floor for benchmarked measures, changing the scoring range to one to ten points.** Small practices are still eligible for the three-point minimum. **MIPS eligible clinicians other than small practices will receive zero measure achievement points for submitted measures that meet the data completeness requirement, but do not have a benchmark or meet the case minimum.** CMS has also removed end-to-end electronic reporting and high-priority or outcome measure bonus points beginning with PY 2022.



To incentivize practices to submit new measures, CMS has finalized a new scoring policy for measures within their first two performance periods in the MIPS program. **Beginning with PY 2023, MIPS eligible clinicians will receive seven measure achievement points for each submitted measure in its first year in MIPS and five measure achievement points for each submitted measure in its second year in MIPS that meet the data completeness requirement but does not have a benchmark or meet the case minimum requirement. For measures that can be reliably scored against a benchmark, MIPS eligible clinicians will receive seven to ten measure achievement points for measures in their first year and five to ten measure achievement points for measures in their second year.**

CMS has finalized the removal of several measures which have historically been used by radiologists reporting through the ACR's NRDR QCDR:

- #21: Perioperative Care: Selection of Prophylactic Antibiotic – First OR Second-Generation Cephalosporin
- #23: Perioperative Care: Venous Thromboembolism (VTE) Prophylaxis (When Indicated in ALL Patients)
- #154: Falls: Risk Assessment
- **#195: Radiology: Stenosis Measurement in Carotid Imaging Reports**
- **#225: Radiology: Reminder System for Screening Mammograms**

Regarding their methodology for scoring topped out measures, **CMS will continue capping measures at seven points if they have been topped out for two or more performance years** but will adjust the score if the measure ceases to be topped out upon completion of data submission for the current performance year.

Quality Data Completeness Requirements (p.1883)

Quality measure submission must continue to account for at **least 70% of total exam volume**. This number defines the minimum subset of patients within a measure denominator that must be reported.

Cost Category (p. 1540)

CMS finalized the Cost performance category weight at 30 percent for PY 2022 and for all subsequent years per the statute.

Due to the COVID-19 PHE, CMS was unable to reliably calculate the cost measure scores for PY 2020 and has decided to assign a weight of zero percent to the cost performance category for that program year.

Five new episode-based Cost measures have been finalized for implementation into MIPS: **Melanoma Resection, Colon and Rectal Resection, Sepsis, Asthma/Chronic Obstructive Pulmonary Disease, and Diabetes**. All these measures have a 20-episode case minimum except



for the Melanoma Resection episode-based cost measure, which has a ten-episode case minimum.

Beginning with PY 2022, stakeholders can develop cost measures to expand the current inventory of episode-based cost measures. CMS will conduct a measure call for cost measures for earliest adoption into the MIPS program by 2024.

Improvement Activities (p. 1410)

CMS will maintain the 15 percent weight for the Improvement Activities category.

CMS will continue to require GPRO (group) reporters to attest to the participation of at least 50 percent of NPIs within the group TIN when attesting to completion of improvement activities. This policy was established in 2020.

The 2022 Final Rule also adds 7 new activities, modifies 15 existing activities, and removes 6 previously adopted activities.

Promoting Interoperability Category (p. 1425)

CMS finalized its proposal to maintain the hardship exception with auto-reweighting for small practices that do not report data on Promoting Interoperability. CMS finalized proposed modifications to measures under the Electronic Prescribing and Public Health and Clinical Data Exchange objectives, as well as consolidation of the required information blocking attestation statements. CMS finalized a proposal to require Promoting Interoperability participants to conduct an annual self-assessment using the [High Priority Practices Guide](#). Finally, CMS tabled its proposed change to the Provider to Patient Exchange objective that would have required indefinite retention of patient data, citing a need for further clarification and reintroduction of this concept in a future proposed rule.

Facility-based Scoring (p.1299)

Facility-based scoring was implemented in 2019. Clinicians and groups would not need to elect or opt-in to facility-based measurement if they were eligible and benefitted from having a higher combined quality and cost performance score.

CMS finalized a new policy to determine the MIPS final score for eligible clinicians and groups. **Beginning with PY 2022, the MIPS quality and cost performance category scores will be based on the facility-based measurement scoring methodology unless a clinician or group receives a higher MIPS final score through another MIPS submission.** This policy calculates two final scores for clinicians and groups who are facility-based: one for the clinician or group's performance and the weights of the performance categories if facility-based measurement did not apply, and another based on the application of facility-based measurement. CMS will accept the higher of the two scores.

Advanced Alternative Payment Models

An Advanced APM is an APM that:

1. Requires participants to use certified EHR technology (CEHRT),



2. Provides payment for covered services based on quality measures comparable to MIPS; and
3. Requires participating entities to bear more than nominal financial risk or participate as a Medical Home Model.

For payment years 2019 through 2024, Qualifying APM Participants (QPs) receive a 5 percent APM Incentive Payment. Starting in payment year 2026, the update to the PFS CF for QPs will be 0.75%. The Consolidated Appropriations Act, 2021, froze the APM payment incentive thresholds for performance years 2021 and 2022 (payment years 2023 and 2024). Therefore, for CY 2022, the QP payment amount threshold will remain at 50 percent of Medicare payments and the QP patient count threshold will remain at 35 percent of Medicare patients. The Partial QP thresholds for payment years 2023 and 2024 (performance years 2021 and 2022) will remain at 40 percent for the payment amount method and 25 percent for the patient count method.

APM Incentive Payment Recipient

CMS is finalizing policy to revise their decision hierarchy for making APM payments so that the Agency would first seek to identify a TIN associated with the QP during the base year, and if no such TIN is identified in the base year, CMS would then seek to identify a TIN associated with the QP during the payment year.

The Radiation Oncology Model is expected to be an Advanced APM in the 2022 QP performance period.

ACR staff and MACRA Committee continue to digest and analyze changes in this rule. A more detailed summary will be published in coming weeks.