CY 2023 Medicare Physician Fee Schedule Final Rule
Summary of Major Provisions

On November 1, 2022, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2023 Medicare Physician Fee Schedule final rule (MPFS). The provisions of the rule are effective January 1, 2023.

Conversion Factor

CMS finalized the 2023 Medicare conversion factor (CF) at $33.06, a reduction of about 4.5% from the CY 2022 CF. The decrease is largely a result of an expiring 3% increase funded by Congress through 2022. The additional approximate 1.6% decrease is the result of budget neutrality requirements that stem from the revised evaluation and management (E/M) changes.

Physician fees under Medicare also face an additional 4% cut as a result of the PAY GO sequester in 2023. This stems from the American Rescue Plan, a $1.9 trillion COVID-19 relief bill which passed in 2021 and triggered cuts across the federal government.

ASH has joined the American Medical Association (AMA) and the medical community as a whole to strongly advocate that Congress avert these payment cuts. Congress must act before the end of the year to prevent this 8.5% payment reduction from taking effect.

Evaluation and Management Services

In 2021, CMS adopted major changes to the office and outpatient E/M visits as recommended by the AMA CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee (RUC), which allowed physicians to select the E/M visit level to bill based on either total time spent on the date of a patient encounter or the medical decision making (MDM) utilized in the provision of the visit.

In this rule, CMS adopted the revised AMA CPT guidelines and codes and the RUC recommended relative values for additional E/M visit code families, including inpatient and observation visits, emergency department (ED) visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment. CMS will allow practitioners to use time or MDM to select the E/M visit level. A medically appropriate history and/or physical exam will be a required element of the services but will no longer impact visit level. CMS is adopting additional changes, including the deletion of observation CPT codes, which would be merged into the existing hospital care CPT code set. CMS also finalized Medicare-specific coding for prolonged services, which is consistent with CMS' previously finalized approach to prolonged office and outpatient E/M services.

CMS finalized reductions to the RVUs for a few of the inpatient and observation E/M visits (CPT codes 99221 – 99223). This is a result of surveys and recommendations from the AMA RUC. CMS accepted the RUC recommendations and is finalizing the new RVUs for 2023.

New Prolonged Inpatient/Observation E/M Code

CMS finalized a new prolonged inpatient/observation E/M code, G0316. This is consistent with the previous final policy for office/outpatient E/M visits, which requires the use of prolonged code, G2212.

G0316 Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99415, 99416, 99418). (Do not report G0316 for any time unit less than 15 minutes).

Split (or Shared) Visits

A split (or shared) visit refers to an E/M service performed by both a physician and a non-physician practitioner (NPP) in the same group practice. Longstanding CMS policy has been that the physician can bill for the split/shared service if he/she performs a "substantive portion" of the encounter. Medicare reimbursement for split/shared services is at 100 percent of the PFS rate, when the physician bills for the service, while reimbursement is at 85 percent of the PFS rate when NPPs bill for the service.

CMS is finalizing a one-year delay of its policy (included in the 2022 MPFS) requiring a physician to see the patient for more than half of the total time of a split or shared E/M visit in order to bill for the service. Through calendar year 2023, physicians would continue to bill split or shared visits based on the current definition of substantive portion as one of the following: history, exam, medical decision-making, or more than half of total time.

CMS believes that this delay will allow for a one-year transition for providers to get accustomed to these changes and adopt their workflow in practice as well as for the implementation of the new coding and payment policies for other E/M services, which become effective in CY 23. ASH has engaged in advocacy requesting that CMS not move forward with split/shared service policy. The delay will provide an opportunity to work with other medical societies and CMS on this issue.

Chronic Pain Management and Treatment (CPM) Bundles (HCPCS G3002 and G3003)

CMS finalized two new HCPCS G-codes to report monthly chronic pain management (CPM) services. Currently no CPT code exists that specifically describes the work of the clinician who performs comprehensive, holistic CPM. In the final rule, CMS notes that the comprehensive care management involved in CPM services may potentially prevent or reduce the need for acute services, such as those due to falls and emergency department visits associated with chronic pain. CMS identified that these codes could be used for individuals with sickle cell disease.

HCPCS code G3002 *(Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally*

provided by physician or other qualified health care professional, per calendar month. (When using G3002, 30 minutes must be met or exceeded.))

HCPCS code G3003 *(Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for G3002. When using G3003, 15 minutes must be met or exceeded.))*

The first time HCPCS code G3002 is billed, the physician or qualified health practitioner must see the beneficiary in-person but then, as noted below, any of the CPM in-person components included in HCPCS codes G3002 and G3003 may be furnished via telehealth, as clinically appropriate, in order to increase access to care for beneficiaries. Additionally, both E/M and CPM may be billed on the same day if all requirements to report each service are met, and time spent providing CPM services does not represent time spent for providing any other reported service. CMS finalized the definition of chronic pain as persistent or recurrent pain lasting longer than 3 months. A work RVU of 1.45 for HCPCS code G3002 and a work RVU of 0.5 for HCPCS code G3003 were finalized.

Payment for Medicare Telehealth Services

CMS finalized the implementation of the provisions of the Consolidated Appropriations Act of 2022 (the Act), which extended certain telehealth flexibilities, including telephone E/M codes (99441-99443), allowed under the COVID-19 public health emergency (PHE), for an additional 151 days after the end of the PHE, and made additions to the Medicare Telehealth Services List. More details below.

As a reminder, telehealth services under Medicare are assigned to one of three categories. Category 1 includes services that are similar to professional consultations, office visits, and office psychiatry services currently on the Medicare Telehealth Services List. Category 2 includes services that are not similar to those on the current Medicare Telehealth Services List (non-E/M). If a service is included in Category 1 or 2, it is considered a covered service via telehealth. Category 3, which was newly created in 2021 due to the COVID-19 pandemic, includes services added to the Medicare Telehealth Services List on a temporary basis and under current policy, these services are slated to remain on the list through the end of 2023 (although CMS noted that this policy may be revised in the event that the PHE extends well into CY 2023).

CMS finalized for permanent addition to the Medicare Telehealth Services List on a Category 1 Basis:

- G0316, new HCPCS code for prolonged inpatient or observation services
- G3002, new HCPCS code for chronic pain management and treatment, monthly
- G3003, new HCPCS code for additional 15 minutes of chronic pain management and treatment

Telephone E/M Services

Although CMS received requests to temporarily add telephone E/M visit codes to the Medicare Telehealth Services List on a Category 3 basis, CMS finalized the policy in the proposed rule to retain CPT codes 99441-99443 on the Medicare Telehealth Services List only through expiration of the 151-day period following the end of the PHE. On the 152nd day these codes will revert to bundled status, meaning they will be covered but not separately payable.

CMS states that current statute requires that telehealth services be analogous to in-person care such that the telehealth service is essentially a substitute for a face-to-face encounter. However, according to CMS, audio-only telephone E/M services are inherently non-face-to-face services, since they are furnished exclusively through remote, audio-only communications. Outside the circumstances of the PHE, the telephone E/M services would not be analogous to in-person care; nor would they be a substitute for a face-to-face encounter. Therefore, CMS does not believe it is appropriate for these codes to remain on the Medicare Telehealth Services List after the end of the PHE and the 151-day post-PHE extension period.

At the conclusion of the PHE and the 151-day extension period, the only Medicare telehealth services that will be permitted to be furnished using audio-only technology will be the mental health telehealth services.

Since the beginning of the COVID-19 pandemic, ASH has joined many others in the patient and provider community to advocate for permanent coverage and payment of the telephone E/M codes. The Society will continue to do so.

Services Proposed for Removal from the Medicare Telehealth Services List After 151 Days Following the End of the PHE

CMS finalized the provision that the originating site for the telehealth service can be any site in the U.S. at which the beneficiary is located when the service is furnished, including the beneficiary's home during the additional 151 days after the end of the PHE. Services extended for the additional 151 days, include, initial observation care (99218-99220); initial hospital care (99221-99223); observation/hospital same day (99234-99236); telephone E/M (99441-99443). On the 152nd day following the end of the PHE these codes will no longer be available via telehealth.

CMS will be issuing separate guidance related to the 151-day extension to help ensure a smooth transition after the end of the PHE (the end date of the PHE is not yet known).

For coding and billing purposes, CMS is finalizing that providers will continue to bill with modifier 95 along with the place of service (POS) code corresponding to where the service would have been furnished in-person through the latter of the end CY 2023 or the end of the calendar year in which the PHE ends. After the 151-day extension, telehealth claims will require the appropriate POS indicator rather than modifier "95".

Expiration of PHE Flexibilities for Direct Supervision Requirements

Under the COVID-19 PHE, CMS has allowed for direct supervision, as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using real-time audio/video technology, instead of requiring their physical presence. Currently, after December 31 of the year in which the PHE ends, this flexibility will end and the pre-PHE rules for direct supervision will apply. As such, CMS expects to continue to permit direct supervision through virtual presence through at least the end of CY 2023 under previously finalized policy, which specifies that it will continue through the end of the calendar year in which the PHE ends.

CMS will consider the comments received for potential future rulemaking. In the proposed rule, CMS sought information on whether the flexibility to meet the immediate availability requirement for direct supervision using real-time audio/video technology should potentially be made permanent. They also sought comment regarding the possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time, audio/video technology for only a subset of services.

Dental and Oral Health Services

CMS requested information on whether, when, and how to potentially cover and pay for dental services.

The final rule codifies and clarifies in regulation that Medicare payment can be made for the following:

- Reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor.
- Stabilization or immobilization of teeth in connection with the reduction of a jaw fracture.
- Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease.
- Dental splints only when used in conjunction with medically necessary treatment of a medical condition.

CMS also finalized that dental services (including both examination and treatment) should be covered prior to cardiac valve replacement, valvuloplasty, or organ transplant, which for the purposes of this policy includes a bone marrow or hematopoietic stem cell transplant. CMS finalized that Medicare payment would be provided if these procedures were done on an outpatient or an inpatient basis. CMS also said that ancillary services (such as X-rays, the administration of anesthesia, or the use of an operating room) for these procedures would also be covered.

ASH provided comments on how dental services are a key component to treating many hematologic diseases and disorders, including sickle cell disease, hemophilia, and many blood cancers, and is pleased to see that CMS finalized coverage of dental services prior to bone marrow or hematopoietic stem cell transplant.

Quality Payment Program

MIPS Value Pathways

The Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) are a subset of measures and activities that can be used to meet MIPS reporting requirements beginning in the 2023 performance year. The MVP framework aims to align and connect measures and activities across the quality, cost, and improvement activities, performance categories of MIPS for different specialties and conditions. MIPS-eligible clinicians will be required to submit measures in five categories (quality, improvement activities, cost, population health, and promoting interoperability). Measures will be chosen from a list curated by CMS that relate to the specific MVP. The measure lists for population health and promoting interoperability will be the same regardless of which MVP is selected.

At this time reporting of MVPs is optional. CMS aims to sunset the traditional MIPS reporting after the 2027 performance year, replacing it completely with MVPs or the Alternative Payment Model

Performance Pathway. Similar to MIPS, physicians participating in MVP can earn a payment adjustment for Part B covered professional services based on CMS's evaluation of reported measures.

In this year's proposed rule, CMS proposed five new MVPs, including the Advancing Cancer Care MVP, which CMS states would be most applicable to clinicians who treat patients within the practice of oncology and hematology. CMS is finalizing the Advancing Cancer Care MVP with some modifications for the CY 2023 performance period/2025 MIPS payment year and future years.

Overall, ASH was pleased that CMS proposed and finalized this MVP, but the Society did highlight that more hematology-specific measures are needed to participation to be meaningful.