CY23 Physician Fee Schedule Proposed Rule

On July 7, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2023 Physician Fee Schedule proposed rule. Comments must be submitted by September 6. The final rule is typically released in early November and the provisions of the rule are effective on January 1, 2023.

This document provides ASH Members with a summary of the major provisions of the Medicare Physician Fee Schedule (MPFS) proposed rule impacting Hematologists/Oncologists, including charts showing physician work relative value units and national average Medicare payment rates for Hem/Onc and evaluation and management (E/M) services.

Conversion Factor

CMS is proposing a reduction of the 2023 Medicare conversion factor (CF) of about 4.5%; from $34.6062 to $33.0775. This is largely a result of the expiration of a 3% increase to the conversion factor at the end of calendar year 2022 as required by law.

Previously, ASH has joined the medical community in engaging Congress to stop the 3% decrease.

Impact of Proposed Rule on Hematology/Oncology Services

Attached to this summary are charts showing the relative values and payment rates for CY 2023 in comparison to those published in the final MPFS for CY 2022. The payment reductions shown in the Hematology/Oncology services chart largely reflect a decrease due to the conversion factor reduction that will occur if Congress does not enact legislation to prevent the cut from taking place. Services provided in a physician office are proposed for somewhat greater reductions.

CMS accepted the recommendations from the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) for most of the evaluation and management (E/M) codes (further detail is provided below). Of note, payment for the subsequent inpatient hospital E/M codes are proposed to increase and payment for the initial hospital E/M codes are proposed to decrease.

Evaluation and Management

CMS is proposing to adopt the majority of the changes recommended by the CPT Editorial Panel and AMA/Specialty Society RVS Update Committee (RUC) to several evaluation and management (E/M) code families, including inpatient and observation visits, emergency medicine, and nursing facility and home visits.

For inpatient and observation codes, the CPT Editorial Panel deleted seven observation care codes and revised nine codes, to create a single set of codes for inpatient and observation care effective January 1, 2023 and redefined these codes so that they parallel the office/outpatient E/M visits (as finalized for January 1, 2021). CMS is proposing to adopt these changes as defined below as well as the RUC recommendations for work RVUs and times:

- The visit level will be selected based on the amount of practitioner time spent with the patient or the level of medical decision making (MDM) as redefined in the CPT E/M Guidelines.
- History and physical exam will only be considered when and to the extent that they are medically appropriate and will no longer be used to select visit level.

For hospital inpatient or observation discharge, CMS is proposing to adopt the CPT recommendations, which include revisions to the two hospital discharge day management codes, CPT codes 99238 and 99239, so that they may be billable for discharge of hospital inpatient or observation patients. CMS is also proposing that a practitioner would not be able to bill prolonged services for hospital discharge (CPT codes 99238 or 99239). CMS is proposing to accept the RUC recommendations for work RVUs and time for CPT codes 99238 and 99239.

New Prolonged Inpatient/Observation E/M Code

CMS is not proposing to adopt the CPT code for prolonged services (code 993X0) and alternatively, is proposing a new HCPCS code, GXXX1, to describe prolonged services associated with certain types of E/M services.

- GXXX1: *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 GXXX1 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0). (Do not report GXXX1 for any time unit less than 15 minutes)*).

This code is being proposed in place of CPT code 993X0 (*Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time.) (List separately in addition to the code of the inpatient and observation Evaluation and Management services*), which was proposed by the CPT Editorial Panel. CMS believes that the billing instructions for CPT code 993X0 will lead to administrative complexity, potentially duplicative payments, and limit the agency's ability to determine how much time was spent with the patient using claims data. Additionally, the newly proposed HCPCS code GXXX1 is consistent with the final policy for O/O E/M visits, which requires the use of prolonged code G2212 for prolonged O/O E/M services.

Split (or Shared) E/M Visits

A split (or shared) visit refers to an E/M visit performed by both a physician and a non-physician practitioner (NPP) in the same group practice. Longstanding CMS policy has been that for split (or shared) visits in the facility setting, the physician can bill for the service if he/she perform a substantive portion of the encounter. Physicians are reimbursed at 100 percent of the PFS rate while NPPs are reimbursed at 85 percent of the PFS rate when they bill for the service. In the CY22 PFS final rule, CMS finalized a phased-in approach to defining substantive portion of the service (except for critical care, which can only be more than half of the total time). For CY22, the definition of substantive portion would be one of the following: history, or exam, or MDM, or more than half of total time. CMS is proposing to delay implementation of this definition until January 1, 2024 and will maintain for another year the definition which had been finalized for CY22 (history, or exam, or MDM, 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.

Payment for Medicare Telehealth Services

In this proposed rule, CMS is implementing the provisions of the Consolidated Appropriations Act of 2022 (the Act), which extended certain telehealth flexibilities, including the 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. More details included 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 currently slated to remain on the list through the end of 2023.

CMS is also proposing to add newly proposed HCPCS prolonged services code GXXX1 to the Medicare Telehealth Services list on a Category 1 basis (a covered telehealth service). More information, including the definition, on this code is provided above.

Telephone E/M Services

CMS received many requests to add the telephone E/M codes (99441-99443) to the Category 3 telehealth list, but the agency is not proposing to include these codes on the Medicare Telehealth Services List on a Category 3 basis. CMS believes that 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, and therefore, CMS does not believe it would be 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.

ASH has heard from members about the benefit of these telephone E/M codes and for the past two years, ASH has advocated for permanent coverage and payment for these codes.

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

The Consolidated Appropriations Act of 2022 extends some of the flexibilities implemented during the PHE for COVID-19 for an additional 151 days after the end of the PHE. During the additional 151 days, 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. 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).

For coding and billing purposes, CMS is proposing that Medicare telehealth services furnished on or before the 151st day after the end of the PHE, will continue to be processed for payment as Medicare telehealth claims when accompanied with the modifier "95" and that physicians and other practitioners

should continue to report the place of service (POS) code that would have been reported had the service been furnished in-person. After the 151-day extension, telehealth claims will require the appropriate POS indicator rather than modifier "95".

Expiration of PHE Flexibilities for Direct Supervisions 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. CMS is continuing to seek information on whether the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time audio/video technology should potentially be made permanent. They are also seeking 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.

Quality Payment Program

MIPS Value Pathways

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.

CMS created MVPs in an effort to streamline the cumbersome and sometimes duplicative reporting requirements under the MIPS program. 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 can earn a payment adjustment for Part B covered professional services based on CMS's evaluation of performance across the different performance categories.

In this year's proposed rule, CMS is proposing five new MVPs. The following MVP is of interest to ASH members:

1. Advancing Cancer Care MVP

CMS is proposing this MVP in support of the Administration's Cancer Moonshot Mission and the importance of cancer care. The proposed Advancing Cancer Care MVP focuses on the clinical theme of providing fundamental treatment and management of cancer care. This MVP would be most applicable to clinicians who treat patients within the practice of oncology and hematology.

Group A: New MVPs Proposed for the CY 2023 Performance Period/2025 MIPS Payment Year and Future Years

A.1 Advancing Cancer Care MVP

In support of the Administration's Cancer Moonshot Mission[7] and the importance of cancer care, we are proposing the Advancing Cancer Care MVP. The proposed Advancing Cancer Care MVP focuses on the clinical theme of providing fundamental treatment and management of cancer care. This MVP would be most applicable to clinicians who treat patients within the practice of oncology and hematology.

Quality Measures

We propose to include eleven MIPS quality measures and two QCDR measures within the quality component of this MVP, which are specific to the clinical topic of cancer by assessing three critical areas: the patient experience of care, end of life care, and appropriate diagnostics along with possible treatment options for different cancer diagnoses. We reviewed the MIPS quality measure inventory and believe the following quality measures provide a meaningful and comprehensive assessment of the clinical care for clinicians who specialize in treating patients with oncologic conditions:

- Q143: Oncology: Medical and Radiation – Pain Intensity Quantified: This MIPS quality measure ensures pain intensity is assessed and quantified in those patients receiving chemotherapy or radiation.
- Q144: Oncology: Medical and Radiation – Plan of Care for Pain: This MIPS quality measure ensures a plan of care is in place for those patients experiencing pain while receiving chemotherapy or radiation.
- Q450: Appropriate Treatment for Patients with Stage I (T1c) – III HER2 Positive Breast Cancer: This MIPS quality measure ensures appropriate treatment for this patient population in accordance with guidelines.
- Q451: RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy: This MIPS quality measure strives to improve concordance with RAS (KRAS and NRAS) testing guidelines for metastatic colorectal cancer patients, by assessing if gene mutation testing was performed prior to therapy.
- Q452: Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies: This MIPS quality measure ensures patients with metastatic colorectal cancer and RAS (KRAS or NRAS) gene mutation are not treated inappropriately with anti-EGFR monoclonal antibodies.
- Q453: Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score – better): This MIPS quality measure assesses appropriate end of life care for cancer patients by reducing the utilization of unnecessary chemotherapy.
- Q457: Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days (lower score – better): This MIPS quality measure assesses appropriate end of life care for cancer patients by increasing the use of hospice services sooner for patients with advanced cancer.
- Q462: Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy: This MIPS quality measure ensures proper bone density evaluation for patients with a care plan including androgen deprivation therapy for 12 or more months to promote positive bone health outcomes.
- PIMSH2: Oncology: Utilization of GCSF in Metastatic Colorectal Cancer: This QCDR measure assesses clinical practice guideline compliance regarding implementation of mutations testing to optimize diagnosis and disease management.
- PIMSH8: Oncology: Mutation testing for lung cancer completed prior to start of targeted therapy: This QCDR measure assesses the use of GCSFs in accordance with current guidelines.

In conjunction with the aforementioned cancer care measures, we propose to include the following broadly applicable MIPS quality measures that are relevant to cancer care. The quality measures below capture the patient's voice regarding their care and support the mental health of patients that are experiencing a cancer diagnosis:

- Q047: Advance Care Plan: This MIPS quality measure captures the clinical interaction of documenting a patient's voice for possible, future life-sustaining medical intervention. This engagement between the clinician (or clinician staff) and the patient allows the patient to be autonomous and communicate their ideal of clinical care that ensures coordinated care is implemented as documented in the patient's medical record.
- Q134: Preventive Care and Screening: Screening for Depression and Follow-Up Plan: This MIPS quality measure ensures all patients are screened for depression with a follow-up plan discussed for those patients who screen positive.
- Q321: CAHPS for MIPS Clinician/Group Survey: This survey provides direct input from patients and their experience regarding timely care, effective communication, shared decision making, care coordination, promotion of health and education, completion of health status/functionality, and courtesy of office staff.

Improvement Activities

Within the improvement activities component of this MVP, we propose to include thirteen improvement activities that reflect actions and processes undertaken by clinicians who provide cancer care to patients, as well as activities that promote patient engagement and patient-centeredness, health equity, shared decision making, and care coordination. These improvement activities provide opportunities for clinicians, in collaboration with patients, to drive outcomes and improve quality of care for cancer patients. The following improvement activities are proposed for inclusion in this MVP:

- IA_BE_4: Engagement of patients through implementation of improvements in patient portal
- IA_BE_6: Regularly Assess Patient Experience of Care and Follow Up on Findings
- IA_BE_15: Engagement of patients, family and caregivers in developing a plan of care
- IA_BE_24: Financial Navigation Program
- IA_CC_1: Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop
- IA_CC_17: Patient Navigator Program
- IA_EPA_1: Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
- IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation
- IA_PM_14: Implementation of methodologies for improvements in longitudinal care management for high risk patients
- IA_PM_15: Implementation of episodic care management practice improvements
- IA_PM_16: Implementation of medication management practice improvements
- IA_PM_21: Advance Care Planning
- IA_PSPA_16: Use of decision support and standardized treatment protocols

Cost Measures

Within the cost component of this MVP, we propose to include the Total Per Capita Cost (TPCC) measure because it captures the overall costs of care after establishing a primary care-type relationship. This includes the care provided to patients by medical, hematological, and gynecological oncologists. The broad focus of the measure, which includes total costs of care for patients with cancer, supports the intent of this MVP to apply to cancer care. Currently, there are no applicable episode-based measures available, but one could be considered for development in the future.

[7] See https://www.whitehouse.gov/briefing-room/statements-releases/2022/02/02/fact-sheet-president-biden-reignites-cancer-moonshot-to-end-cancer-as-we-know-it/.

TABLE A.1: Advancing Cancer Care MVP

As noted in the introduction of this appendix, we considered measures and improvement activities available within the MIPS inventory and selected those that we determined best fit the clinical concept of the proposed Advancing Cancer Care MVP. We request comment on the measures and activities included in this MVP.

Quality	Improvement Activities	Cost
(!) Q047: Advance Care Plan (Collection Type: Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications) **(*) Q134:** Preventive Care and Screening: Screening for Depression and Follow-Up Plan (Collection Type: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications) **(*)(!) Q143**: Oncology: Medical and Radiation – Pain Intensity Quantified (Collection Type: eCQM Specifications, MIPS CQMs Specifications) **(!) Q144:** Oncology: Medical and Radiation – Plan of Care for Pain (Collection Type: MIPS CQMs Specifications) **(*)(!) Q321:** CAHPS for MIPS Clinician/Group Survey (Collection Type: CAHPS Survey Vendor) **(!) Q450:** Appropriate Treatment for Patients with Stage I (T1c) – III HER2 Positive Breast Cancer (Collection Type: MIPS CQMs Specifications) **Q451:** RAS (KRAS and NRAS) Gene Mutation Testing Performed for Patients with Metastatic Colorectal Cancer who receive Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibody Therapy	**IA_BE_4:** Engagement of patients through implementation of improvements in patient portal (Medium) **IA_BE_6:** Regularly Assess Patient Experience of Care and Follow Up on Findings (High) **IA_BE_15:** Engagement of patients, family and caregivers in developing a plan of care (Medium) **IA_BE_24:** Financial Navigation Program (Medium) **IA_CC_1**: Implementation of Use of Specialist Reports Back to Referring Clinician or Group to Close Referral Loop (Medium) **IA_CC_17:** Patient Navigator Program (High) **(~) IA_EPA_1:** Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record (High) **(%) IA_PCMH:** Electronic submission of Patient Centered Medical Home accreditation **(~) IA_PM_14:** Implementation of methodologies for improvements in longitudinal care management for high risk patients (Medium) **IA_PM_15:** Implementation of episodic care management practice improvements (Medium) **IA_PM_16:** Implementation of medication management practice improvements	**Total Per Capita Cost (TPCC)**

(Collection Type: MIPS CQMs Specifications) **(!) Q452:** Patients with Metastatic Colorectal Cancer and RAS (KRAS or NRAS) Gene Mutation Spared Treatment with Anti-epidermal Growth Factor Receptor (EGFR) Monoclonal Antibodies (Collection Type: MIPS CQMs Specifications) **(*)(!) Q453:** Percentage of Patients Who Died from Cancer Receiving Chemotherapy in the Last 14 Days of Life (lower score – better) (Collection Type: MIPS CQMs Specifications) **(!!) Q457:** Percentage of Patients Who Died from Cancer Admitted to Hospice for Less than 3 days (lower score – better) (Collection Type: MIPS CQMs Specifications) **(*) Q462:** Bone Density Evaluation for Patients with Prostate Cancer and Receiving Androgen Deprivation Therapy (Collection Type: eCQM Specifications) **(#)(!) PIMSH2:** Oncology: Utilization of GCSF in Metastatic Colorectal Cancer (Collection Type: QCDR) **(#)(!) PIMSH8:** Oncology: Mutation testing for lung cancer completed prior to start of targeted therapy (Collection Type: QCDR)	(Medium) **IA_PM_21:** Advance Care Planning (Medium) **IA_PSPA_16:** Use of decision support and standardized treatment protocols (Medium)	

Foundational Layer	
Population Health Measures	**Promoting Interoperability**
(!!) Q479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Eligible Clinician Groups (Collection Type: Administrative Claims) **(!!) Q484:** Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Collection Type: Administrative Claims)	Security Risk Analysis Safety Assurance Factors for EHR Resilience Guide (SAFER Guide) e-Prescribing **(*)** Query of the Prescription Drug Monitoring Program (PDMP) Provide Patients Electronic Access to Their Health Information Support Electronic Referral Loops By Sending Health Information AND Support Electronic Referral Loops By Receiving and Reconciling Health Information **OR** Health Information Exchange (HIE) Bi-Directional Exchange OR **(^)** Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) Immunization Registry Reporting Syndromic Surveillance Reporting (Optional) Electronic Case Reporting Public Health Registry Reporting (Optional) Clinical Data Registry Reporting (Optional) Actions to Limit or Restrict Compatibility or Interoperability of CEHRT ONC Direct Review

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Audiologist	$70	0%	1%	-1%	0%
Cardiac Surgery	$197	-1%	-1%	0%	-1%
Cardiology	$6,298	0%	-1%	0%	-1%
Chiropractic	$669	-1%	1%	0%	0%
Clinical Psychologist	$784	-1%	0%	-1%	-2%
Clinical Social Worker	$853	-1%	0%	-1%	-2%
Colon and Rectal Surgery	$155	-1%	-1%	0%	-1%
Critical Care	$351	1%	0%	1%	1%
Dermatology	$3,751	-1%	0%	0%	0%
Diagnostic Testing Facility	$811	0%	3%	0%	2%
Emergency Medicine	$2,530	0%	0%	1%	1%
Endocrinology	$532	0%	0%	0%	0%
Family Practice	$5,777	0%	0%	0%	0%
Gastroenterology	$1,589	0%	0%	1%	0%
General Practice	$371	0%	0%	0%	0%
General Surgery	$1,758	-1%	-1%	0%	-1%
Geriatrics	$175	2%	0%	0%	3%
Hand Surgery	$255	-1%	0%	0%	0%
Hematology/Oncology	$1,707	0%	-1%	0%	-1%
Independent Laboratory	$594	0%	-1%	0%	-1%
Infectious Disease	$586	4%	0%	1%	5%
Internal Medicine	$9,804	2%	0%	1%	3%
Interventional Pain Mgmt	$924	-1%	-1%	0%	-1%
Interventional Radiology	$465	-1%	-3%	0%	-4%
Multispecialty Clinic/Other Phys	$150	0%	-1%	0%	0%
Nephrology	$2,021	1%	0%	0%	1%
Neurology	$1,397	0%	0%	0%	-1%
Neurosurgery	$727	-1%	0%	1%	0%
Nuclear Medicine	$53	-1%	-1%	-1%	-3%
Nurse Anes / Anes Asst	$1,116	-1%	0%	0%	-1%
Nurse Practitioner	$5,802	1%	0%	0%	2%
Obstetrics/Gynecology	$592	-1%	0%	0%	-1%
Ophthalmology	$4,835	-1%	0%	0%	0%
Optometry	$1,306	-1%	0%	0%	-1%
Oral/Maxillofacial Surgery	$72	-1%	-1%	0%	-2%
Orthopedic Surgery	$3,461	-1%	0%	0%	0%
Other	$58	0%	-1%	0%	-2%
Otolarngology	$1,134	-1%	0%	0%	-1%
Pathology	$1,163	-1%	0%	0%	-1%
Pediatrics	$57	0%	0%	0%	0%
Physical Medicine	$1,090	2%	0%	0%	2%
Physical/Occupational Therapy	$4,978	-1%	1%	-1%	-1%
Physician Assistant	$3,165	0%	0%	0%	0%
Plastic Surgery	$320	-1%	0%	0%	0%
Podiatry	$1,991	-1%	-1%	0%	-2%
Portable X-Ray Supplier	$77	0%	2%	0%	1%
Psychiatry	$978	1%	0%	0%	2%
Pulmonary Disease	$1,395	1%	0%	1%	2%
Radiation Oncology and Radiation Therapy Centers	$1,609	-1%	0%	0%	-1%
Radiology	$4,712	-1%	-1%	-2%	-3%
Rheumatology	$546	-1%	-1%	0%	-2%
Thoracic Surgery	$315	-1%	-1%	0%	-1%
Urology	$1,752	-1%	-1%	0%	-1%
Vascular Surgery	$1,098	0%	-3%	0%	-3%

2023 Proposed Physician Fee Schedule (CMS–1770–P)										
Payment Rates for Medicare Physician Services - Hematology/Oncology										
CPT Code	Descriptor	2023	NON-FACILITY (OFFICE)				FACILITY (HOSPITAL)			
			2023		2022	% payment	2023		2022	% payment
		Work RVUs	Total RVUs	Payment CF=$33.0775	Payment CF=$34.6062	change 2022 to 2023	Total RVUs	Payment CF=$33.0775	Payment CF=$34.6062	change 2022 to 2023
20939	Bone marrow aspir bone grfg	1.16	NA	N/A	NA	NA	2.12	$70.12	$70.94	-1.2%
36430	Blood transfusion service	0.00	1.18	$39.03	$39.11	-0.2%	NA	NA	NA	NA
36511	Apheresis wbc	2.00	NA	NA	NA	NA	3.24	$107.17	$110.39	-2.9%
36512	Apheresis rbc	2.00	NA	NA	NA	NA	3.14	$103.86	$107.97	-3.8%
36513	Apheresis platelets	2.00	NA	NA	NA	NA	3.13	$103.53	$107.63	-3.8%
36514	Apheresis plasma	1.81	16.90	$559.01	$593.84	-5.9%	2.74	$90.63	$94.82	-4.4%
36516	Apheresis, selective	1.56	52.95	$1,751.45	$1,891.23	-7.4%	2.53	$83.69	$86.17	-2.9%
36522	Photopheresis	1.75	40.81	$1,349.89	$1,447.58	-6.7%	2.84	$93.94	$97.94	-4.1%
38205	Harvest allogenic stem cells	1.50	NA	N/A	NA	NA	2.48	$82.03	$86.86	-5.6%
38206	Harvest auto stem cells	1.50	NA	NA	NA	NA	2.46	$81.37	$85.82	-5.2%
38220	Bone marrow aspiration	1.20	4.65	$153.81	$160.57	-4.2%	2.00	$66.16	$68.87	-3.9%
38221	Bone marrow biopsy	1.28	4.83	$159.76	$167.15	-4.4%	2.07	$68.47	$71.63	-4.4%
38222	Dx bone marrow bx & aspir	1.44	5.25	$173.66	$180.99	-4.1%	2.24	$74.09	$77.17	-4.0%
38230	Bone marrow collection	3.50	NA	NA	NA	NA	6.09	$201.44	$207.64	-3.0%
38232	Bone marrow harvest autolog	3.50	NA	NA	NA	NA	5.73	$189.53	$201.06	-5.7%
38240	Bone marrow/stem transplant	4.00	NA	NA	NA	NA	7.09	$234.52	$246.05	-4.7%
38241	Bone marrow/stem transplant	3.00	NA	NA	NA	NA	5.24	$173.33	$181.34	-4.4%
38242	Lymphocyte infuse transplant	2.11	NA	NA	NA	NA	3.70	$122.39	$128.04	-4.4%
88184	Flowcytometry/ tc, 1 marker	0.00	1.85	$61.19	$69.21	-11.6%	NA	NA	NA	NA
88185	Flowcytometry/ tc, add-on	0.00	0.55	$18.19	$22.15	-17.9%	NA	NA	NA	NA
88187	Flowcytometry/read, 2-8	0.74	1.02	$33.74	$35.99	-6.3%	1.02	$33.74	$35.99	-6.3%
88188	Flowcytometry/read, 9-15	1.20	1.83	$60.53	$62.98	-3.9%	1.83	$60.53	$62.98	-3.9%
88189	Flowcytometry/read, 16 & <	1.70	2.46	$81.37	$84.44	-3.6%	2.46	$81.37	$84.44	-3.6%
96360	Hydration iv infusion, init	0.17	0.99	$32.75	$34.95	-6.3%	NA	NA	NA	NA
96361	Hydrate iv infusion, add- on	0.09	0.38	$12.57	$13.15	-4.4%	NA	NA	NA	NA
96365	Ther/ proph/ diag iv inf, init	0.21	1.89	$62.52	$69.21	-9.7%	NA	NA	NA	NA
96366	Ther/ proph/ dg iv inf, add- on	0.18	0.61	$20.18	$21.46	-5.9%	NA	NA	NA	NA
96367	Tx/ proph/ dg addl seq iv inf	0.19	0.87	$28.78	$30.80	-6.6%	NA	NA	NA	NA
96368	Ther/ diag concurrent inf	0.17	0.59	$19.52	$20.76	-6.0%	NA	NA	NA	NA
96372	Ther/ proph/ diag inj, sc/ im	0.17	0.42	$13.89	$14.53	-4.4%	NA	NA	NA	NA
96373	Ther/ proph/ diag inj, ia	0.17	0.54	$17.86	$18.34	-2.6%	NA	NA	NA	NA
96374	Ther/ proph/ diag inj, iv push	0.18	1.11	$36.72	$40.14	-8.5%	NA	NA	NA	NA
96375	Ther/ proph/ diag inj add- on	0.10	0.46	$15.22	$16.26	-6.4%	NA	NA	NA	NA
96377	Applicaton on-body injector	0.17	0.55	$18.19	$19.38	-6.1%	NA	NA	NA	NA
96401	Chemotherapy, sc/im	0.21	2.17	$71.78	$77.86	-7.8%	NA	NA	NA	NA
96402	Chemo hormon antineopl sq/ im	0.19	1.02	$33.74	$33.91	-0.5%	NA	NA	NA	NA
96405	Intralesional chemo admin	0.52	2.50	$82.69	$86.86	-4.8%	0.84	$27.79	$29.07	-4.4%
96406	Intralesional chemo admin	0.80	3.94	$130.33	$137.39	-5.1%	1.33	$43.99	$45.33	-3.0%
96409	Chemo, iv push, sngl drug	0.24	3.02	$99.89	$107.97	-7.5%	NA	NA	NA	NA
96411	Chemo, iv push, addl drug	0.20	1.63	$53.92	$58.83	-8.3%	NA	NA	NA	NA
96413	Chemo, iv infusion, 1 hr	0.28	3.92	$129.66	$140.16	-7.5%	NA	NA	NA	NA
96415	Chemo, iv infusion, addl hr	0.19	0.84	$27.79	$29.76	-6.6%	NA	NA	NA	NA
96416	Chemo prolong infuse w/ pump	0.21	3.85	$127.35	$137.39	-7.3%	NA	NA	NA	NA
96417	Chemo iv infus each addl seq	0.21	1.90	$62.85	$68.17	-7.8%	NA	NA	NA	NA
96420	Chemotherapy, push technique	0.17	3.10	$102.54	$110.74	-7.4%	NA	NA	NA	NA
96422	Chemotherapy,infusion method	0.17	4.73	$156.46	$168.53	-7.2%	NA	NA	NA	NA
96423	Chemo, infuse method add-on	0.17	2.18	$72.11	$77.86	-7.4%	NA	NA	NA	NA
96425	Chemotherapy,infusion method	0.17	5.10	$168.70	$181.34	-7.0%	NA	NA	NA	NA
96440	Chemotherapy, intracavitary	2.12	22.61	$747.88	$805.29	-7.1%	3.94	$130.22	$134.62	-3.3%
96446	Chemotx admn prtl cavity	0.37	5.69	$188.21	$203.83	-7.7%	0.74	$24.48	$27.34	-10.5%
96450	Chemotherapy, into CNS	1.53	4.95	$163.73	$173.72	-5.8%	2.27	$75.09	$77.52	-3.1%
96521	Port pump refill & main	0.21	3.79	$125.36	$142.23	-11.9%	NA	NA	NA	NA
96522	Refill/ maint pump/ resvr syst	0.21	3.50	$115.77	$125.27	-7.6%	NA	NA	NA	NA
96523	Irrig drug delivery device	0.04	0.77	$25.47	$27.34	-6.8%	NA	NA	NA	NA
96542	Chemotherapy injection	0.75	3.89	$128.67	$136.00	-5.4%	1.25	$41.35	$42.91	-3.6%

2023 Proposed Physician Fee Schedule (CMS–1770–P)										
Payment Rates for Medicare Physician Services - Evaluation and Management										
CPT Code	Descriptor	2023	NON-FACILITY (OFFICE)				FACILITY (HOSPITAL)			
			2023		2022	% payment	2023		2022	% payment
		Work RVUs	Total RVUs	Payment CF=$33.0775	Payment CF=$34.6062	change 2022 to 2023	Total RVUs	Payment CF=$33.0775	Payment CF=$34.6062	change 2022 to 2023
99202	Office o/p new sf 15-29 min	0.93	2.16	$71.45	$74.06	-3.5%	1.43	$47.30	$49.49	-4.4%
99203	Office o/p new low 30-44 min	1.60	3.32	$109.82	$113.85	-3.5%	2.44	$80.71	$84.44	-4.4%
99204	Office o/p new mod 45-59 min	2.60	4.97	$164.40	$169.57	-3.0%	3.96	$130.99	$136.69	-4.2%
99205	Office o/p new hi 60-74 min	3.50	6.54	$216.33	$224.25	-3.5%	5.39	$178.29	$185.49	-3.9%
99211	Office o/p est minimal prob	0.18	0.69	$22.82	$23.53	-3.0%	0.26	$8.60	$9.00	-4.4%
99212	Office o/p est sf 10-19 min	0.70	1.66	$54.91	$57.45	-4.4%	1.04	$34.40	$36.68	-6.2%
99213	Office o/p est low 20-29 min	1.30	2.68	$88.65	$92.05	-3.7%	1.95	$64.50	$67.48	-4.4%
99214	Office o/p est mod 30-39 min	1.92	3.80	$125.69	$129.77	-3.1%	2.88	$95.26	$98.97	-3.8%
99215	Office o/p est hi 40-54 min	2.80	5.34	$176.63	$183.07	-3.5%	4.25	$140.58	$147.08	-4.4%
99221	Initial hospital care	1.63	NA	NA	NA	NA	2.45	$81.04	$100.70	-19.5%
99222	Initial hospital care	2.60	NA	NA	NA	NA	3.86	$127.68	$135.31	-5.6%
99223	Initial hospital care	3.50	NA	NA	NA	NA	5.17	$171.01	$198.29	-13.8%
99231	Subsequent hospital care	1.00	NA	NA	NA	NA	1.46	$48.29	$38.76	24.6%
99232	Subsequent hospital care	1.59	NA	NA	NA	NA	2.35	$77.73	$71.29	9.0%
99233	Subsequent hospital care	2.40	NA	NA	NA	NA	3.50	$115.77	$102.43	13.0%
99291	Critical care first hour	4.50	8.19	$270.90	$282.39	-4.1%	6.37	$210.70	$219.06	-3.8%
99292	Critical care addl 30 min	2.25	3.57	$118.09	$123.20	-4.1%	3.19	$105.25	$110.05	-4.4%
99421	Ol dig e/m svc 5-10 min	0.25	0.44	$14.55	$15.23	-4.4%	0.38	$12.57	$13.15	-4.4%
99422	Ol dig e/m svc 11-20 min	0.50	0.85	$28.12	$29.76	-5.5%	0.73	$24.15	$25.95	-7.0%
99423	Ol dig e/m svc 21+ min	0.80	1.38	$45.65	$48.45	-5.8%	1.18	$39.03	$41.87	-6.8%
99446	Interprof phone/online 5-10	0.35	0.51	$16.87	$18.69	-9.7%	0.51	$16.87	$18.69	-9.7%
99447	Interprof phone/online 11-20	0.70	1.06	$35.06	$36.68	-4.4%	1.06	$35.06	$36.68	-4.4%
99448	Interprof phone/online 21-30	1.05	1.58	$52.26	$55.02	-5.0%	1.58	$52.26	$55.02	-5.0%
99449	Interprof phone/online 31/>	1.40	2.14	$70.79	$73.71	-4.0%	2.14	$70.79	$73.71	-4.0%
99451	Ntrprof ph1/ntrnet/ehr 5/>	0.70	1.06	$35.06	$36.34	-3.5%	1.06	$35.06	$36.34	-3.5%
99452	Ntrprof ph1/ntrnet/ehr rfrl	0.70	0.97	$32.09	$37.03	-13.3%	0.97	$32.09	$37.03	-13.3%
99453	Rem mntr physiol param setup	0.00	0.57	$18.85	$19.03	-1.0%	NA	NA	NA	NA
99454	Rem mntr physiol param dev	0.00	1.48	$48.95	$55.72	-12.1%	NA	NA	NA	NA
99457	Rem physiol mntr 20 min mo	0.61	1.43	$47.30	$50.18	-5.7%	0.88	$29.11	$31.15	-6.5%
99458	Rem physiol mntr ea addl 20	0.61	1.16	$38.37	$40.84	-6.0%	0.88	$29.11	$31.15	-6.5%
99471	Ped critical care initial	15.98	NA	NA	NA	NA	22.95	$759.13	$793.87	-4.4%
99472	Ped critical care subsq	7.99	NA	NA	NA	NA	11.66	$385.68	$404.89	-4.7%
99487	Cmplx chron care w/o pt vsit	1.81	3.94	$130.33	$134.27	-2.9%	2.69	$88.98	$92.74	-4.1%
99489	Cmplx chron care addl 30 min	1.00	2.08	$68.80	$70.60	-2.5%	1.48	$48.95	$51.22	-4.4%
99490	Chron care mgmt srvc 20 min	1.00	1.85	$61.19	$64.02	-4.4%	1.49	$49.29	$51.56	-4.4%
99491	Chrnc care mgmt svc 30 min	1.50	2.49	$82.36	$86.17	-4.4%	2.23	$73.76	$77.52	-4.8%
99495	Trans care mgmt 14 day disch	2.78	6.05	$200.12	$209.02	-4.3%	4.12	$136.28	$144.65	-5.8%
99496	Trans care mgmt 7 day disch	3.79	8.20	$271.24	$281.69	-3.7%	5.63	$186.23	$195.87	-4.9%
G0396	Alcohol/subs interv 15-30mn	0.65	1.04	$34.40	$35.99	-4.4%	0.94	$31.09	$32.88	-5.4%
G0397	Alcohol/subs interv >30 min	1.30	2.02	$66.82	$69.21	-3.5%	1.93	$63.84	$66.10	-3.4%
G0506	Comp asses care plan ccm svc	0.87	1.81	$59.87	$62.64	-4.4%	1.29	$42.67	$45.33	-5.9%
GXXX1	Prolong hosp inpt each ad 15m	0.61	0.93	$30.76	NA	NA	0.89	$29.44	NA	NA