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CMS CY 2023 Medicare Physician Fee Schedule Rules

On July 7, the Centers for Medicare & Medicaid Services (CMS) released the Medicare Physician Fee Schedule (MPFS) proposed rule for CY 2023 (CMS-1770-P). This rule updates payment policies and payment rates for Part B services furnished under the MPFS, as well as makes changes to the Quality Payment Program (QPP).

Comments are due on September 6. Note that the page numbers listed in this document refer to the display copy of the proposed rule.

Conversion Factor for 2023

The conversion factor for 2023 is set to decrease by approximately 4.5% from $34.6026 to $33.0775. The decrease is due to:

- the expiration of the 3% increase to payments due to expire at the end of 2022
- a mandated 0% conversion factor increase
- budget neutrality adjustments.

Impact on Specialties

Estimated Specialty Level Impact for 2023

Specialty	Medicare Allowed Charges (millions)	Impact Work RVU	Impact PE RVU	Impact MP RVU	Combined Impact
Infectious Diseases	$586	4%	0%	1%	+5%
Internal Medicine	$9,804	2%	0%	1%	+3%
Urology	$1,752	-1%	-1%	0%	-1%
Vascular Surgery	$1,098	0%	-3%	0%	-3%
Interventional Radiology	$465	-1%	-3%	0%	-4%

Source: https://www.auanet.org/advocacy/comment-letters-and-resources/physician-payment-and-coverage-issues/2023-physician-fee-schedule-proposed-rule-summary

Note that the impact table, Table 138, page 1439 in the proposed rule **does not** include the 3% cut described above. It only includes impacts of rate- setting changes and changes to RVUs within the budget neutral system. Note that 2023 is the second year of phase-in for the clinical labor updates to the practice expense component of the PFS. The table for the Estimated Specialty Level Impacts is excerpted from Table 138, page 1439.

Note: if finalized, the rule would result in the conversion factor dropping below early 1990s levels. The rule does not account for inflation or COVID-related challenges and impacts more than 27 specialties.

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Evaluation and Management (E/M) Visits
CMS is proposing to adopt most of the changes in coding and documentation for Other E/M visits (which include hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment) recommended by the American Medical Association's CPT and RUC panels effective January 1, 2023. CMS is also proposing to maintain the current billing policies that apply to the E/Ms while they consider potential revisions that might be necessary in future rulemaking.

This revised coding and documentation framework would include CPT code definition changes (revisions to the Other E/M code descriptors), including:

- New descriptor times (where relevant).
- Revised interpretive guidelines for levels of medical decision making.
- Choice of medical decision making or time to select code level (except for a few families like emergency department visits and cognitive impairment assessment, which are not timed services).
- Eliminated use of history and exam to determine code level (instead there would be a requirement for a medically appropriate history and exam).

CMS proposes to maintain the current billing policies that apply to the E/Ms while they consider potential revisions that might be necessary in future rulemaking. CMS is also proposing to create Medicare-specific coding for payment of Other E/M prolonged services, similar to what CMS adopted in CY 2021 for payment of Office/Outpatient prolonged services.

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Updated Medicare Economic Index (MEI) for CY 2023
CMS is proposing to rebase and revise the MEI cost share weights for CY 2023 and is soliciting comments regarding the rebasing and revision of the MEI, which measures the input price pressures of providing physician services.

CMS is proposing a new methodology for estimating base year expenses that relies on publicly available data from the U.S. Census Bureau NAICS 6211 Offices of Physicians. This proposed methodology allows for the use of data that are more reflective of current market conditions of physician ownership practices, rather than only reflecting costs for self-employed physicians, and will allow for the MEI to be updated on a more regular basis.

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Using the new MEI cost weights to set PFS rates would not change overall spending on PFS services, but would likely result in significant changes to payments among PFS services. CMS is proposing not to use the proposed updated MEI cost share weights to set PFS payment rates for CY 2023 in consideration of CMS's ongoing efforts to update to the PFS payment rates with more predictability and transparency, and in the interest in ensuring payment stability.

Split (or Shared) E/M Visits
For CY 2023, CMS is proposing to delay the split (or shared) visits policy finalized in CY 2022 for the definition of substantive portion, as more than half of the total time, for one year with a few exceptions. Therefore, for CY 2023, as in CY 2022, the substantive portion of a visit may be met by any of the following elements:

- History
- Performing a physical exam
- Making a medical decision
- Spending time (more than half of the total time spent by the practitioner who bills the visit)

Under this proposal, clinicians who furnish split (or shared) visits will continue to have a choice of history, physical exam, or medical decision making, or more than half of the total practitioner time spent to define the substantive portion, instead of using total time to determine the substantive portion, until CY 2024.

Telehealth Services
CMS is proposing a number of policies related to Medicare telehealth services including making several services that are temporarily available as telehealth services for the PHE available through CY 2023 on a Category III basis, which will allow more time for collection of data that could support their eventual inclusion as permanent additions to the Medicare telehealth services list.

CMS is proposing to extend the duration of time that services are temporarily included on the telehealth services list during the PHE, but are not included on a Category I, II, or III basis for a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act, 2022 (CAA, 2022).

CMS is proposing to implement the telehealth provisions in the CAA, 2022 via program instruction or other sub regulatory guidance to ensure a smooth transition after the end of the PHE. These policies extend certain flexibilities in place during the PHE for 151 days after the PHE ends, such as allowing telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home,

allowing certain services to be furnished via audio-only telecommunications systems, and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services. The CAA, 2022 also delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.

CMS is proposing that telehealth claims will require the appropriate place of service (POS) indicator to be included on the claim, rather than modifier “95,” after a period of 151 days following the end of the PHE and that modifier “93” will be available to indicate that a Medicare telehealth service was furnished via audio-only technology, where appropriate.

Requiring Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs to Provide Refunds with Respect to Discarded Amounts

Section 90004 of the Infrastructure Investment and Jobs Act (Pub. L. 117-9, November 15, 2021) amended section 1847A of the Act adding provisions that require manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug. The refund amount is the amount of discarded drug that exceeds an applicable percentage, which is required to be at least 10%, of total allowed charges for the drug in a given calendar quarter. The proposals to implement section 90004 of the Infrastructure Act include: how discarded amounts of drugs are determined; a definition of which drugs are subject to refunds (and exclusions); when and how often CMS will notify manufacturers of refunds; when and how often payment of refunds from manufacturers to CMS is required; refund calculation methodology (including applicable percentages); a dispute resolution process; and enforcement provisions.