

CY 2023 PHYSICIAN FEE SCHEDULE PROPOSED RULE SUMMARY

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). The rule in its entirety and the addenda, including Addendum B, which lists the proposed RVUs for each CPT code can be found here. Comments are due on September 6.

In this proposed rule, CMS discusses several significant policy changes and includes requests for information (RFI). The following summarizes the major policies in the proposal. Note that the page numbers listed in this document refer to the display copy of the proposed rule.

REGULATORY IMPACT ANALYSIS – P. 1423

Highlight: Medicare payments for physician services set for a 4.5% decrease.

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 which was enacted by law last year but is due to expire at the end of 2022, which is then coupled with a mandated 0% conversion factor increase and the required budget neutrality adjustments.

Specialty Level Impact of the Proposed Changes

The impact to group practices and the individual physicians, however, varies based on practice type and the mix of patients and services provided to those patients. 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 and depicts some of the specialties with the greatest impact both positive and negative. We have included other specialties in this table so that one can see briefly which specialties have fared the best and which have fared the worst.

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%
Endocrinology	\$532	0%	0%	0%	0%
Vascular Surgery	\$1,098	0%	-3%	0%	-3%
Interventional Radiology	\$465	-1%	-3%	0%	-4%

EVALUATION AND MANAGEMENT (E/M) VISITS – P. 297

Highlight: CMS accepts RUC recommended values for inpatient and observation E/M services. Creates new G code for prolonged services.

Several years ago, the AMA set out to revise the entire CPT[®] evaluation and management (E/M) code set with the culmination of that effort discussed in this proposed rule. Revised E/M codes outlined in this rule include inpatient and observation visits, emergency department (ED) visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment. In the CY 2020 and 2021 rules, CMS implemented changes to the outpatient E/M services.

CMS is proposing to adopt nearly all the revisions for CPT[®] codes used to report other E/M visits including inpatient and observation services. The changes include revisions to the documentation guidelines and to the descriptors for these services, which will now mirror those previously made to the outpatient E/M services. Inpatient E/M code level may be chosen based on time or medical decision making, and like the outpatient E/M codes, using the history and exam to determine code level has been eliminated, but should be performed when medically necessary.

Prolonged Services

CMS is proposing changes for the reporting of prolonged services. Specifically, the rule discusses creating a single prolonged service code which may be used to bill for a prolonged service for only the highest level of initial inpatient visit (99223), subsequent inpatient visit (99233) and hospital inpatient or observation care (admission and discharge) (99236) E/M services. The proposed GXXX1 is described in the rule as follows *“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, 99415, 99416). (Do not report GXXX1 for any time unit less than 15 minutes.”*

The proposed G-code would take the place of the 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).* The agency does not support this code created by the CPT Editorial Panel as the agency believes that “the billing instructions for CPT code 993X0 will lead to administrative complexity, potentially duplicative payments, and limit our ability to determine how much time was spent with the patient using claims data.”

Per the proposal, the newly created **G-code may only be used if the practitioner is using time to select the E/M code level**, and therefore may only be reported when the services upper limit of time has been exceeded for 99223, 99233, and 99236. Below are the coding guidelines that CMS is proposing for the use of the prolonged services code:

- The prolonged time begins 15 minutes after the total times for 99223, 99233 and 99236 have been met.
- The code is for 15-minute increments, and the entire 15 minutes must be met or exceeded before the G-code may be used.
- The total time will be rounded to the nearest 5 minutes. For example, 74 minutes for 99223 will be rounded to 75 minutes for administrative simplification.
- Time spent is face-to-face and non-face-to-face on the date of the encounter for initial (99223) and subsequent (99233) services and for three days after for 99236.

CMS is proposing a total RVU of 0.89 for GXXX1 for the facility setting (0.61 work RVU, 0.25 PE RVU and 0.3 malpractice RVU). The table for Time Thresholds excerpted from Table 18 Proposed Time Thresholds to Report Other E/M Prolonged Services (p.347).

Time Thresholds to Report GXXX1 for Prolonged Services

Primary E/M Service	Prolonged Service Code	Time Threshold to Report Prolonged Code	Count Physician Time/NPP time spent within this time period (surveyed time frame)
Initial IP/Obs. Visit (99223)	GXXX1	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	GXXX1	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	GXXX1	125 minutes	Date of visit to three days after

Proposed Definition of Initial and Subsequent - p. 310

A portion of the definition for initial and subsequent in the CPT code book notes that subspecialty within the same practice may be included when determining if a visit is initial or subsequent for the physician providing the service. Given that CMS does not recognize subspecialties, CMS is proposing revised definitions of initial and subsequent as follows:

- An initial service would be defined as one that occurs when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **same specialty** who belongs to the same group practice during the stay.
- A subsequent service would be defined as one that occurs when the patient has received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the **same specialty** who belongs to the same group practice during the stay.

Note that the only change is the elimination of the word “subspecialty” from each definition.

Valuation of Hospital Inpatient or Observation Care Services – p. 318

As noted previously, CMS has accepted the CPT Panel revisions for codes used to report inpatient and observation care services. Additionally, the agency has proposed to accept without revision, the RUC recommended work RVUs and associated times for initial and subsequent services and for inpatient/observation same day services. Current and 2023 time and work RVUs for inpatient and observation E/M services is depicted in the table below.

Current Work RVUs and Time for Inpatient and Observation Services vs. 2023

CPT Code	2022 wRVU	2022 Intraservice Time	2022 Total Time	2023 wRVU	2023 Intraservice Time	2023 Total Time
99221 – initial inpatient, low MDM	1.92	30	50	1.63	40	40
99222 – initial inpatient, moderate MDM	2.61	40	75	2.60	55	55
99223 – initial inpatient, high MDM	3.86	55	90	3.50	74	74
99231 – subsequent inpatient, low MDM	0.76	10	20	1.00	25	25
99232 – subsequent inpatient, moderate MDM	1.39	20	40	1.59	36	36
99233 – subsequent inpatient, high MDM	2.00	30	55	2.40	52	52
99234 – inpatient or observation care, same day, low MDM	2.56	40	69	2.00	45	50
99235 – inpatient or observation care, same day, moderate MDM	3.24	50	83.8	3.24	68	76
99236 – inpatient or observation care, same day, high MDM	4.20	55	94	4.30	85	97

Split/Shared Services - p. 348

CMS is proposing to delay the much-debated split/shared services policy for another year, until 2024. In 2022, CMS finalized, but then delayed a proposal which stated that the practitioner who billed the split/shared service should be based on substantive time (more than 50% of total time) spent with the patient. However, this policy was met with resistance, as stakeholders noted that time should not necessarily be the deciding factor when billing for a service and that medical decision making should also be considered. Note that under this policy, if a non-physician practitioner (NPP) performed at least half of the E/M visit (by time), then Medicare would only pay 85% of the MPFS rate.

In 2022 CMS has allowed that the substantive portion of a visit may be determined either by the practitioner who spent more than 50% providing the service or determined the practitioner who provided the medical decision making (MDM) for the service. And now for 2023 CMS is proposing to delay again the implementation of using its definition of substantive time. Therefore, clinicians will have a choice to use history and physical exam or MDM, or more than half the total time in making determinations for “substantive portion” of a visit. Note that the agency is not proposing to change its definition of substantive portion, only that it will delay enforcement until January 1, 2024. CMS believes this additional time prior to enforcement will allow providers and hospital teams to change workflow patterns and adjust to the new coding rules.

VALUATION OF SPECIFIC CODES FOR CY 2023 – P. 131

Highlight: CMS only proposed to accept 75% of the RUC's recommendations.

Insertion, and Removal and Insertion of new 180-Day Implantable Interstitial Glucose Sensor System (HCPCS codes G0308 and G0309) – p. 212

For CY 2021, CMS previously established pricing for three Category III CPT codes that describe the services for inserting, removing, and removing and inserting an implantable interstitial glucose sensor from a subcutaneous pocket. The FDA recently approved a 180-day continuous glucose monitoring system, increasing the monitoring period from 90- to 180-days to allow for a longer period before replacing the sensor, and CMS established two G-codes to apply to the newly approved system:

- HCPCS code G0308 (*Creation of subcutaneous pocket with insertion of 180-day implantable interstitial glucose sensor, including system activation and patient training*); and
- G0309 (*removal of implantable interstitial glucose sensor with creation of subcutaneous pocket at different anatomic site and insertion of new 180-day implantable sensor, including system activation*).

These two G-codes are currently contractor priced and became effective on July 1, 2022. CMS is now seeking information and invoices from stakeholders on the costs of the 180-day glucose supply and smart transmitter inputs to establish PE inputs for these services, which would inform national payment amounts for CY 2023.

NON-FACE-TO-FACE/REMOTE THERAPEUTIC MONITORING (RTM) SERVICES – P. 402

Remote Therapeutic Monitoring (RTM) is a family of five codes – three practice expense (PE) only codes and two treatment management codes – finalized for Medicare payment in the CY 2022 MPFS rule. In that rule, CMS permitted therapists and other qualified healthcare practitioners (QHPs), including CSWs, CRNAs, PTs, OTs, and SLPs, to bill the RTM codes.

Regarding the treatment management codes (CPT codes 98980 and 98981), CMS and stakeholders have expressed concern about whether these codes may be billed by qualified NPPs outside of “incident to” billing rules. In response to these concerns, CMS is proposing to create four new HCPCS G codes – one pair of codes aimed at reducing physician and non-physician practitioner (NPP) supervisory burden and the second pair aimed at increasing patient access to RTM services. As a result of these changes, CMS is proposing to change the status of CPT codes 98980 and 98981 to non-payable by Medicare.

Proposal to Develop Two HCPCS G-Codes Allowing General Supervision of Auxiliary Personnel

Stakeholders have expressed concern that, as for most “incident to” services, the clinical labor activities described in the direct PE of CPT codes 98980 and 98981 must be furnished under the direct supervision of the billing practitioner, which imposes burden on physicians and NPPs who are delivering services to patients. To address this, CMS has proposed to create two HCPCS G-codes – a base code and an add-on code – that may be furnished by auxiliary personnel under general, not direct, supervision. The two new G-codes, GRTM1 and GRTM2, will include physician work and direct PE inputs as currently described in CPT codes 98980 and 98981.

Proposed G Codes for General Supervision for RTM

Code	Long Descriptor	Work RVU
HCPCS code GRTM1	Remote therapeutic monitoring treatment management services, physician or NPP professional time over a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month; first 20 minutes of evaluation and management services.	0.62
HCPCS code GRTM2	Remote therapeutic monitoring treatment management services, physician or NPP professional time over a calendar month requiring at least one interactive communication with the patient/caregiver over a calendar month; each additional 20 minutes of evaluation and management services during the calendar month (List separately in addition to code for primary procedure).	0.61

Proposal to Develop Two HCPCS G-Codes that Allow Certain Qualified Nonphysician Healthcare Professionals to Furnish RTM Services

CMS is proposing to create two new codes – HCPCS codes GRTM3 and GRTM4 – that may facilitate RTM services furnished by qualified nonphysician healthcare professionals who cannot bill under Medicare Part B for services furnished “incident to” their professional services. Neither of the two proposed new codes include clinical labor inputs in the direct PE.

Proposed G Codes for Qualified Nonphysician Healthcare Professionals to Furnish RTM Services

Code	Long Descriptor	Work RVU
HCPCS code GRTM3	Remote therapeutic monitoring treatment assessment services, first 20 minutes furnished personally/directly by a nonphysician qualified health care professional over a calendar month requiring at least one interactive communication with the patient/caregiver during the month.	0.62
HCPCS code GRTM4	Remote therapeutic monitoring treatment assessment services, additional 20 minutes furnished personally/directly by a nonphysician qualified health care professional over a calendar month requiring at least one interactive communication with the patient/caregiver during the calendar month (List separately in addition to code for primary procedure).	0.61

Request for Information: Development of a Generic Device Code for RTM

Stakeholders have asked CMS to develop a generic device code for RTM; however, the agency has instead decided seek comments to inform new coding relating to devices. CMS seeks input on:

- Types of data collected using RTM devices, and how the data that are collected solve specific health conditions and what those health conditions are;
- The costs associated with RTM devices that are available to collect RTM data;
- How long the typical episode of care by condition type might last; and
- The potential number of beneficiaries for whom an RTM device might be used by the health condition type.

STRATEGIES FOR IMPROVING GLOBAL SURGICAL PACKAGE VALUATION - P. 49

Highlight: CMS is requesting comments on the payment for E/M services paid under the global surgical package.

CMS continues to grapple with the payment for services under the global surgical package construct. In recent years, the agency has studied this issue and solicited public comment as to the best way to pay for services included in a surgical procedure, including E/M visits pre- and post-surgery. Therefore, once again, CMS has asked for comments seeking ways to pay for the global surgical package that is fair and equitable.

As noted in the rule, CMS has continued concern that E/M visits associated/paid under a global surgical package are not being performed. CMS has asked for “comments from the public on ideas for other sources of data that would help us to assess global package valuation (including the typical number and level of E/M services), as well as our data collection methodology and the RAND report findings.” Other areas of comment include:

- Has the postoperative landscape changed such that global surgical packages are no longer relevant?
- Have changes in the “number and level of postoperative E/M visits needed to provide effective follow-up care to patients; the timing of when postoperative care is being provided; and who is providing the follow-up care” affected how the global surgical package is utilized.
- Have recent changes to the E/M code set, including the revisions in both language and payment for the office visit E/Ms affected the global surgical package.

The above is a sampling of comment options. More information and other areas of consideration when commenting can be found on pages 56-59 of the proposed rule.

STRATEGIES FOR UPDATES TO PRACTICE EXPENSE DATA COLLECTION AND METHODOLOGY - P. 42

Highlight: CMS is seeking comment on updating indirect practice expense inputs, not proposing any changes for 2023.

In this rule, CMS is seeking comment as to the best approach for updating the indirect practice data inputs within the practice expense in future rulemaking. Indirect practice expenses are those costs associated with office rent, infrastructure costs such as computers and printers, and other non-clinical expenses associated with operating a medical practice. While no new policies are proposed for 2023,

CMS would like to collaborate with stakeholders in developing an updated methodology that is “consistent, transparent, and predictable.” The indirect practice expense inputs have not been updated since the late 2000’s when the Physician Practice Expenses Survey (PPIS) was last fielded by the American Medical Association.

CMS, as is the theme throughout the rule, would like to update or correct methodology and policies that adversely affect certain MPFS services, which may then lead to access to care issues or disparities in care or outcomes. Thus, CMS is seeking comment on the following topics for updating the indirect practice expense (p. 46):

- New and innovative designs and revisions for a PE survey, and how to field that survey.
- Means to ensure that any potential survey is representative of the physicians and non-physicians providing services to Medicare beneficiaries, which includes different ownership types, specialties, geographies, and affiliations.

CMS is also seeking comment on alternatives to a survey which may include innovative methodologies or other means to determine indirect practice costs such as:

- *Use of statistical clustering or other methods that would facilitate a shift away from specialty-specific inputs to inputs that relate to homogenous groups of specialties without a large change in valuation relative to the current PE allocations.*
- *Avenues by which indirect PE can be moved for facility to non-facility payments, based on data reflecting site of service cost differences.*
- *Methods to adjust PE to avoid the unintended effects of undervaluing cognitive services due to low indirect PE.*
- *A standardized mechanism and publicly available means to track and submit structured data and supporting documentation that informs pricing of supplies or equipment.*
- *Sound methodological approaches to offset circularity distortions, where variable costs are higher than necessary costs for practices with higher revenue.*

Finally, the agency seeks comment on how to phase-in changes and methodologies as the agency begins to transform the collection of data associated with practice expenses within the MPFS.

REQUEST FOR INFORMATION: MEDICARE POTENTIALLY UNDERUTILIZED SERVICES - P. 246

Highlight: CMS would like to explore how increase the provision of high-value services to Medicare beneficiaries such as annual wellness visits, screenings for certain diseases states, and treatment for obesity.

The agency has requested comments on the utilization or lack thereof, for high-value services for Medicare beneficiaries. A high-value service is defined as a “service that provide the best possible health outcomes at the lowest possible cost and will improve health, avoid harms, and eliminate wasteful practices.” As noted previously, this proposed rule is policy heavy, particularly seeking ways to reduce disparities within the Medicare payment system. CMS sees this as an opportunity to collect information on services that provide high value to the Medicare beneficiary, while simultaneously addressing health disparity issues.

As such the agency is seeking comments on barriers to providing such services, ways to improve access to services and even addressing payment for those services. Examples of high value, underutilized services include the following:

- Preventive Services, Annual Wellness Visits, Diabetes Management Training, Screening for Diabetes, Referral to appropriate education/prevention/training services, Immunizations/vaccinations, Cancer screenings, Cardiac rehabilitation services, Intensive Behavioral Therapy for obesity, Opioid treatment programs, Complex/Chronic Care Management, Cognitive Assessment & Care, and Behavioral Health Integration Services

CMS is seeking comment how current policy affects access to high value services, if payment or procedural changes within the Medicare payment system could reduce barriers, as well as seeking information on “new and innovative ideas to help broaden perspectives about potential solutions.” The following list of comment options and ideas, along with other information may be found on page 246 of the rule.

- Educational or marketing strategies (informed by beneficiary input) to promote awareness of available programs and resources that advance the utilization of “high value” services.
- Aligning of Medicare and other payer coding, payment and documentation requirements, and processes related to “high value” services.
- Recommendations from States and other interested parties regarding how to best raise awareness of underutilized services, with special consideration for the dual-eligible population.
- Enabling of operational flexibility, feedback mechanisms, and data sharing that would enhance the utilization of “high value” services.
- New recommendations regarding when and how CMS issues regulations and policies related to “high value” services and how CMS can advance rules and policies for beneficiaries, clinicians, and providers.

GEOGRAPHIC PRACTICE COST INDICES (GPCIs) – P. 352

Highlight: The GPCIs are due for an update in 2023. CMS is proposing technical changes to the factors included in calculating the GPCIs.

Given that the costs of living are higher in some areas versus others it follows that the cost of providing Medicare services varies by geographic region. Therefore, CMS must adjust payments accordingly. The Geographic Practice Cost Indices (GPCIs) are used to calculate and adjust payment for the various geographic regions within the US. CMS is required to update the GPCI adjustments every three years, which means that the agency has proposed revisions to the 2023 GPCI amounts and proposed changes to the calculations and data inputs. For more information and detailed explanation of the GPCI see page 352 of the proposed rule.

REBASING AND REVISING THE MEDICARE ECONOMIC INDEX (MEI) - P. 458

Highlight: CMS is seeking comments on revisions to the MEI, but not proposing any changes for 2023.

CMS is proposing to rebase (change the base year of data used in the calculation) and revise (change the sample of data used for the calculation). The MEI measures input price pressures on providing physician services. The agency will move the base year from 2006 to 2017 and will use publicly available data from the U.S. Census Bureau NAICS 6211 Offices of Physicians. The use of the new data will reflect physician ownership of practices, rather than consisting only of data from self-employed physicians. While CMS has asked for comments in this rule on the new methodology, it will not be implementing any changes in 2023.

Payment for Medicare Telehealth Services Under Section 1834(m) of the Act - p. 76

Highlight: CMS is proposing changes to Medicare’s telehealth policies in this rule, some of which will prepare practitioners for delivering and reporting these services after the end of the public health emergency.

Of note, the agency outlines changes to the telehealth services list; how it plans to implement the 151-day extension of certain telehealth flexibilities authorized by Congress in the Consolidated Appropriations Act, 2022 (P.L. 117-103); what modifier should be appended to telehealth claims after the public health emergency; the status of virtual direct supervision; and the proposed Medicare telehealth originating site facility fee for CY 2023.

Changes to the Medicare Telehealth Services List

CMS is proposing to add additional services to the Medicare telehealth list with a Category 3 designation, which are services added on a temporary basis through the end of CY 2023 and may be considered for permanent addition when the requirements for Category 1 or Category 2 services can be met. Requests for services to be added to the telehealth list on a permanent basis must be received each year by February 10 for evaluation and potential inclusion in the following calendar year’s list.

CMS has received requests to add telephone E/M services on a Category 3 basis and reiterated the decision not to add these services to the list on a Category 3 basis. CMS notes that telephone services are not analogous to in-person care or a substitute for a face-to-face encounter outside of the circumstances of the public health emergency, while acknowledging these services can be used to deliver mental health services to patients in their homes under certain circumstances after the public health emergency based on relevant statutory authority.

The agency is proposing to add the new HCPCS codes for prolonged services associated with certain types of E/M services—GXXX1, GXXX2 and GXXX3—to the telehealth list on a Category 1 basis since those codes are replacing the existing prolonged service codes, which are currently on the Category 1 list.

CMS is proposing to allow all services that were added to the telehealth list on a temporary basis during the PHE, including those that have not been converted to Category 1, 2 or 3, to remain available through the 151-day period after the end of the PHE authorized by Congress in the Consolidated Appropriations Act, 2022 for certain telehealth flexibilities to remain in place.

CMS received a request to add Ambulatory Continuous Glucose Monitoring (CPT code 95251) to the Medicare Telehealth Services List on a Category 3 basis but is not proposing to do so. The service does

not meet the requirements to be added to the list because it is inherently non-face-to-face and cannot be substituted for an in-person visit, which are requirements for being added to the list.

Implementation of Provisions Included in the Consolidated Appropriations Act, 2022

The Consolidated Appropriations Act, 2022 (P.L. 117-103) requires the continued waiver of the originating site and geographic restrictions, and coverage of services designated for delivery via audio-only on the date of enactment on March 15, 2022. Given that the end date of the PHE is not yet known and may occur before the rulemaking process for the CY 2023 MPFS is complete, and that the changes made by these provisions are very specific and concise, CMS is providing notice that it intends to issue program instructions or other sub-regulatory guidance to effectuate the changes required by statute when appropriate.

Telehealth Service Modifiers

At the start of the public health emergency, CMS directed physicians to report the place of service (POS) code that would have been reported if that telehealth visit had occurred in-person. To facilitate this, physicians were instructed to add modifier “95” to claims to indicate a telehealth service along with the appropriate POS code. During the 151-day extension of certain telehealth flexibilities after the public health emergency concludes, CMS will continue to process Medicare telehealth claims that include modifier “95” as well as the appropriate POS code as had been the practice during the public health emergency. After the telehealth extension period concludes, modifier “95” will no longer be required and CMS is proposing that the following POS indicators for telehealth services:

- POS “02” – This code would be redefined, if finalized, as Telehealth Provided Other than in Patient’s Home (*Descriptor: The location where health services and health related services are provided or received, through telecommunication technology. Patient is not located in their home when receiving health services or health related services through telecommunication technology.*); and
- POS “10” - Telehealth Provided in Patient’s Home (*Descriptor: The location where health services and health related services are provided or received through telecommunication technology. Patient is in their home (which is a location other than a hospital or other facility where the patient receives care in a private residence) when receiving health services or health related services through telecommunication technology.*).

Payment for these services will be made at the facility payment rate in accordance with established CMS policy. The agency continues to believe the facility payment amount best reflects the direct and indirect practices expenses of telehealth services.

Further, the agency is proposing that a physician billing for telehealth services using audio-only communication technology shall append modifier “93” (*Synchronous Telemedicine Service Rendered Via Telephone or Other Real-Time Interactive Audio-Only Telecommunications System: Synchronous telehealth medicine service is defined as a real-time interaction between a physician or other qualified health care professional and a patient who is located away at a distant site from the physician or other qualified health care professional. The totality of the communication of information exchanged between the physician or other qualified health care professional and the patient during the synchronous telemedicine service must be of an amount and nature that is sufficient to meet the key components and/or requirements of the same service when rendered via a face-to-face interaction*) to claims for which audio-only technology is permitted beginning January 1, 2023.

Supervising practitioners should continue to append the “FR” modifier on any telehealth claims for when required to be present through an interactive real-time, audio and video telecommunications link, as the service may require.

Comment Solicitation on Virtual Direct Supervision

CMS has finalized policy that on December 31 in the year in which the public health emergency ends the pre-public health emergency rules for direct supervision would again apply, meaning the temporary exception to allow immediate availability for direct supervision through a virtual presence will no longer apply. At this time, CMS is requesting additional information on whether the flexibility to meet the availability requirement for direct supervision through virtual presence should be made permanent and whether this should only be applied to a subset of services should it be made permanent.

Telehealth Originating Site Facility Fee

The telehealth statute established a Medicare telehealth originating site facility fee that is updated based on the Medicare Economic Index (MEI). For CY 2023, CMS is proposing HCPCS code Q3014 (*Telehealth originating site facility fee*) is \$28.61.

CHANGES TO THE QUALITY PAYMENT PROGRAM – P. 1099

TRANSFORMING THE MERIT-BASED INCENTIVE PAYMENT SYSTEM (MIPS): MIPS VALUE PATHWAY STRATEGY – P. 1124

Highlight: CMS notes that MIPS will be phased out, and replaced entirely by MVPs, but a timeline has not been set.

CMS is proceeding with the transition to the MIPS Value Pathways (MVPs) to improve value, reduce burden, inform patient choice in selecting clinicians, and reduce barriers to participation in Alternative Payment Models (APMs). MVPs will be available for voluntary reporting beginning with the CY 2023 MIPS performance period, and the agency intends for MVPs to be the only method to participate in MIPS in future years, although they have not yet finalized timing to sunset traditional MIPS. CMS is requesting comments on how to address challenges with specialist reporting of quality performance data.

MVP Development and Reporting Requirements - p. 1131

Highlight: CMS will have twelve new MVPs available for reporting in 2023.

CMS is proposing to modify the MVP development process to allow the agency to evaluate a submitted candidate MVP on an ongoing basis through the MVP development process and will then post a draft version of the submitted candidate MVP on the QPP website to solicit feedback for a 30-day period. CMS would then review the feedback submitted and determine if any changes should be made to the MVP before including it in proposed rulemaking.

CMS proposed to modify the MVP maintenance process so that stakeholders are able to submit their recommendations for potential revisions to established MVPs on a yearly rolling basis. If any submitted recommendations are considered feasible and appropriate, the agency will host a webinar where stakeholders may offer feedback on any potential revisions. Any revisions are then made through notice and comment rulemaking. The agency requests comment on these two proposed changes.

CMS has proposed 12 MVPs for CY 2023 performance period. Last year, CMS finalized seven MVPs that will be available for reporting in the CY 2023 performance period:

- Advancing Rheumatology Patient Care
- Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes
- Advancing Care for Heart Disease
- Optimizing Chronic Disease Management
- Adopting Best Practices and Promoting Patient Safety within Emergency Medicine
- Improving Care for Lower Extremity Joint Repair
- Patient Safety and Support of Positive Experiences with Anesthesia

CMS is also proposing revisions to these MVPs based on the proposed removal of certain activities and the addition of other relevant quality measures. See Appendix 3: MVP Inventory (p. 2052) for proposed revisions.

CMS has proposed five new MVPs:

- Advancing Cancer Care: most applicable to clinicians who treat patients within the practice of oncology and hematology
- Optimal Care for Kidney Health: most applicable to clinicians who treat patients within the practice of nephrology
- Optimal Care for Neurological Conditions: most applicable to clinicians who treat patients within the practice of neurology
- Supportive Care for Cognitive-based Neurological Conditions: most applicable to clinicians who treat patients within the practice of neurology
- Promoting Wellness: most applicable to clinicians who treat patients within the practice of preventive medicine, internal medicine, family medicine, and geriatrics

See Appendix 3: MVP Inventory (p. 2037) for details on the proposed new MVPs.

CMS has proposed to provide clarification on options for how multispecialty groups who practice in team-based care can report MVPs. The agency encourages multispecialty groups to consider adopting subgroup reporting before it becomes mandatory in the CY 2026 performance period.

For subgroup reporting, CMS proposed several changes: 1) to modify the definition of single specialty group and multispecialty group; 2) to add subgroup description requirements to the registration process; 3) to limit the number of subgroups a clinician may participate in to one subgroup per TIN; 4) establish the subgroup determination period; 5) apply new policies for scoring administrative claims measures and cost measures for subgroups; and 6) not assign a subgroup final score to registered subgroups that do not submit data.

APM PERFORMANCE PATHWAY – P. 1159

CMS finalized the APM Performance Pathway (APP) beginning in performance year 2021, which was designed to provide predictable and consistent MIPS reporting options to reduce reporting burden and encourage continued APM participation. CMS is proposing to modify the language and remove the reference to subgroup scoring of the APP, which would clarify that reporting of the APP by a subset of a

group is not allowed. In the future, CMS could propose changes to allow subgroup reporting if this is of interest to MIPS eligible clinicians.

MIPS PERFORMANCE CATEGORY SCORING - P. 1161

Highlight: Addressing health equity is a priority for CMS. New measures created to better understand the issues.

The Merit-based Incentive Payment System (MIPS) is one of two tracks under the Quality Payment Program, which allows for Medicare Part B providers to participate in a performance-based payment system.

CMS seeks feedback on the potential **INCLUSION** of two new measures in the APP measure set:

- MUC21-136: Screening for Social Drivers of Health
- MUC21-134: Screen Positive Rate for Social Drivers of Health

CMS seeks feedback on the following questions to better understand the type and structure of health equity measures that would be appropriate for implementation in MIPS:

- How would a measure best capture health equity need under MIPS in the future?
- How would a measure’s quality action provide actionable information and link to improvement in the quality of care provided to populations with health inequities? Would a measure be meaningful to clinicians in small practices or Federally Qualified Health Centers that may have limited or no access to referral services?
- What, if any, would be the limitations in data interpretation if a future health equity related measure would not be risk-adjusted?
- Would there be any concerns if a future health equity-related measure did not specify requirements for use of consistent tool(s) for data collection under such a measure? Should such a future measure support flexibility in choice of tools while requiring standardized coding of responses to support interoperability?

CMS also seeks feedback on two potential approaches to measure health equity in MIPS and MVPs: assessing the collection and use of self-reported patient characteristics or assessing patient-clinician communication.

Quality Performance Category – p. 1164

CMS is proposing several changes to the quality performance category:

- Revise the definition of the term “high priority measure” to include quality measurement pertaining to health equity
- Replace the “Asian language survey completion” variable with “language other than English spoken at home” variable in the case-mix adjustment model for the Consumer Assessment of Healthcare Providers and Systems (CAHPS) for MIPS Survey
- Increase the data completeness criteria threshold to at least 75 percent for CY 2024 and CY 2025 performance periods/2026 and 2027 MIPS payment years
- Modify the MIPS quality measure set to include the addition of nine new measures, updates to several specialty sets, removal of **FIFTEEN** existing measures, and substantive changes to seventy-five existing measures

CMS is considering developing quality measure to address amputation avoidance in diabetic patients, which would assess the percent of patients with diabetes who receive neurologic and vascular assessments of their lower extremities to determine ulcer risk, have a documented ulcer risk level, and who receive a follow-up plan of care if identified as high risk for ulcer. CMS seeks feedback on questions under consideration for the development of both a process and a composite measure.

Cost Performance Category – p. 1187

CMS is proposing to update the operational list of care episode and patient condition groups and codes by adding the Medicare Spending per Beneficiary (MSPB) Clinician cost measure as a care episode group.

Improvement Activities Performance Category – p. 1191

CMS is proposing changes to the improvement activities inventory for the CY 2023 performance period/2025 MIPS payment year and future years, including adding four new improvement activities, modifying five existing improvement activities, and removing six previously adopted improvement activities.

The four new proposed improvement activities aim to advance health equity and reduce health disparities:

- Use Security Labeling Services Available in Certified Health IT for Electronic Health Record Data to Facilitate Data Segmentation
- Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients
- Create and Implement a Language Access Plan
- COVID-19 Vaccine Promotion for Practice Staff

Promoting Interoperability Performance Category (page 1199)

For the 2024 MIPS payment year and each subsequent payment year, the performance period for the Promoting Interoperability performance category is a minimum of any continuous 90-day period within the calendar year that occurs two years prior to the applicable MIPS payment year, up to and including the full calendar year. CMS is not proposing any changes to the performance period.

Beginning with the performance period in CY 2023, CMS has proposed to require the Query of PDMP measure for MIPS eligible clinicians participating in the Promoting Interoperability performance category. Two exclusions are proposed: 1) any MIPS eligible clinician who is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs in accordance with applicable law during the performance period, and 2) any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period.

CMS also has proposed to expand the Query of PDMP measure to include Schedule III and IV drugs, in addition to Schedule II opioids. CMS seeks feedback on these proposals, as well as feedback on barriers to reporting on this measure, barriers related to technology solutions, cost, and workflow that are faced by MIPS eligible clinicians.

CMS has proposed to add a new measure to the Health Information Exchange Objective beginning with the CY 2023 performance period: Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure. This would offer health care providers more opportunities to earn credit for the Health Information Exchange Objective and would incentivize health care providers to enable exchange under TEFCA, which is critical to advancing health care data exchange nationwide.

Under the Public Health and Clinical Data Exchange Objective, CMS has proposed to revise the options under Active Engagement to consolidate the existing first two options (initial registration and the testing and validation process). The proposed option two would be the existing option three, validated data production. Furthermore, beginning with CY 2023 performance period, MIPS eligible clinicians would only be able to spend one performance period at the pre-production and validation level of active engagement per measure; they must progress to the validated data production level in the next performance period for which they report a particular measure.

CMS seeks comment on how to further promote equitable patient access and use of their health information without adding unnecessary burden on the MIPS eligible clinician or group. Specific questions for feedback are included in the proposed rule.

MIPS FINAL SCORE METHODOLOGY – P. 1255

Highlight: The agency proposes to make technical changes to calculating the final MIPS score.

CMS continues to build on the scoring methodology finalized in prior years, which allows for accountability and alignment across the performance categories and minimizes burden on MIPS eligible clinicians. For the CY 2023 performance period/2025 MIPS payment year, CMS is proposing the following:

- Revise the benchmarking policy to score administrative claims measures in the quality performance category using a benchmark calculated from performance period data
- Clarify the topped-out measure policy and update the topped-out measure life cycle for scoring topped-out measures in the quality performance category
- Establish a maximum cost improvement score of 1 percentage point out of 100 for the cost performance category beginning with the CY 2022 performance period/2024 MIPS payment year

CMS is proposing the following changes for calculating the final score:

- A facility-based MIPS eligible clinician would be eligible to receive the complex patient bonus
- Request information on which additional risk indicators and data sources CMS should consider for use within the complex patient bonus formula to better assess the social and medical complexity for the patients of MIPS eligible clinicians
- Propose that virtual groups would be eligible for facility-based measurement
- Propose changes to the definition of a facility-based MIPS eligible clinician

CMS is proposing to establish the performance threshold for the CY 2025 MIPS payment year using 2019 MIPS payment year data. The performance threshold would be the mean of the final scores for all MIPS eligible clinicians, which is 75 points (rounded up from 74.56). CMS aims to provide performance feedback to MIPS eligible clinicians and groups on or around July 1 of each year, but due to the PHE and COVID-19, feedback may be received later.

THIRD PARTY INTERMEDIARIES GENERAL REQUIREMENTS – P. 1287

Highlight: The agency signals that telehealth is a valuable tool by proposing to add an indicator to clinician and group profile pages on HHS' Care Compare website that would clarify the clinicians offering telehealth services.

CMS allows eligible clinicians to participate in MIPS using third party intermediaries that collect or submit data on their behalf, which improves flexible reporting options. CMS is proposing to update the definition of a third-party intermediary to include subgroups and AMP Entities. CMS proposed to revise Qualified Clinical Data Registry (QCDR) measure self-nomination and measure approval requirements, including to delay the QCDR measure testing requirement for traditional MIPS by an additional year (until the CY 2024 performance period/2026 MIPS payment year). CMS also proposed to revise the remedial action and termination of third-party intermediaries' policies. Finally, CMS included two RFIs on third party intermediary support of MVPs and national continuing medical education (CME) organizations becoming a new type of third-party intermediary.

Public Reporting on the Compare Tools hosted by HHS – p. 1306

CMS is considering adding an indicator to clinician and group profile pages on HHS' Care Compare website that would clarify the clinicians offering telehealth services. CMS would identify clinicians who perform telehealth services using Place of Service Code 02 on carrier claims, or modifier 95 appended on paid claims. CMS would then use a 6-month lookback period and refresh the telehealth indicator bi-monthly, to ensure that when a time-limited Category 3 telehealth code expires, a clinician who only bills telehealth services under the expired code would no longer have a telehealth indicator on their profile page. CMS seeks comment on this proposal.

CMS is proposing to publicly report Medicare procedural utilization on the Compare tool clinician and group profile pages. This may allow patients and caregivers to make more informed healthcare decisions. CMS would begin publicly reporting this data no earlier than CY 2023. CMS seeks comment on this proposal.

CMS seeks comment on ways to incorporate health equity into public reporting on practitioner profile pages with the goal of ensuring that patients and caregivers may easily access meaningful information to assist with healthcare decision making.

OVERVIEW OF THE APM INCENTIVE – P. 1315

Highlight: CMS is seeking comments for options to incent providers to become a qualifying APM participants.

Under the QPP, an eligible clinician who is a Qualifying APM Participant (QP) for a performance year earns an APM Incentive Payment, which is made in the corresponding payment year for payment years 2019 through 2024. This payment is made based on the clinician's QP status in the QP Performance Period that is two years prior, and the APM Incentive Payment is equal to five percent of the eligible clinician's estimated aggregate payments for covered professional services in the base period.

CMS notifies QPs for whom they are unable to identify an appropriate TIN to make the APM Incentive Payment through an annual notice in the Federal Register. CMS is proposing to update the specified

cutoff date from November 1 to September 1 of the payment year, or 60 days from the date on which the agency makes the initial round of payments, whichever is later.

Payment Year 2024 is the final year for which the statute authorizes an APM Incentive Payment. After performance year 2022/payment year 2024, there is no further statutory authority for a 5 percent APM Incentive Payment for eligible clinicians who become QPs for a year. In performance year 2023/payment year 2025, the statute does not provide for any type of incentive for eligible clinicians who become QPs. CMS is concerned that the statutory incentive structure beginning in the 2023 performance year/2025 payment year could lead to a drop in Advanced APM participation.

To address this in future rulemaking, CMS seeks public comment that they can use to identify potential options for the 2024 performance period/2026 payment year, and beyond. Specifically, the agency seeks comment on whether administrative action is needed, and if so, what would be the best approach to address the multi-faceted issues that arise with the end of statutory authority for an APM Incentive Payment for QPs, including the following questions:

- What are your primary considerations going forward as you choose whether to participate in an Advanced APM or be subject to MIPS reporting requirements and payment adjustments? What factors are the most important as you make this decision?
- If you are participating in an Advanced APM now and have been or could be a QP for a year, will the end of the 5 percent lump-sum APM Incentive Payments beginning in the 2025 payment year (associated with the 2023 QP Performance Period) cause you to consider dropping your participation in the Advanced APM, which would mean forgoing QP determinations, thereby ensuring you are subject to MIPS reporting requirements and payment adjustments?
- Going forward, attaining QP status for a year through sufficient participation in one or more Advanced APMs will enable an eligible clinician to, for a year: (1) continue receiving any financial incentive payments available under the Advanced APM(s) in which they participate, subject to the terms and conditions applicable to the specific Advanced APM(s); (2) be paid under the PFS in the payment year using the a higher QP conversion factor (0.75 percent rather than 0.25 percent) beginning in payment year 2026; and (3) not be subject to MIPS reporting requirements or payment adjustments. Do these three conditions provide sufficient incentives for you to participate in an Advanced APM, or would you instead decide to be subject to MIPS reporting requirements and payment adjustments?
- Are there other advantages of MIPS participation that might lead a clinician to prefer MIPS over participation in an Advanced APM, such as: (1) quality measurement that may be specific to a particular practice area or specialty area; or (2) the desire for more precise accountability through public reporting of quality measure performance in the future?

Advanced APMs

CMS is proposing several changes to policies on Advanced APM criteria, as well as providing clarification around payment based on quality measures, and has proposed to modify the period of applicability for the generally applicable nominal amount standard.

CMS is considering discontinuing the policy to calculate Threshold Scores and make most QP determinations at the APM Entity level, to instead make all QP determinations at the individual eligible clinician level. CMS requests feedback on whether this approach should be explored in future rulemaking.

Appendix A

New Quality Measures Proposed for the 2023 Performance Period/2025 MIPS Payment Year and Future Payment Years

- Psoriasis – Improvement in Patient-Reported Itch Severity
- Dermatitis – Improvement in Patient-Reported Itch Severity
- Screening for Social Drivers of Health
- Kidney Health Evaluation
- Adult Kidney Disease: Angiotensin Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy
- Appropriate Intervention of Immune-Related Diarrhea and/or Colitis in Patients Treated with Immune Checkpoint Inhibitors
- Mismatch Repair (MMR) or Microsatellite Instability (MSI) Biomarker Testing Status in Colorectal Carcinoma, Endometrial, Gastroesophageal, or Small Bowel Carcinoma
- Risk-Standardized Acute Cardiovascular-Related Hospital Admission Rates for Patients with Heart Failure under the Merit-based Incentive Payment System
- Adult Immunization Status

Appendix B

Proposed Changes to Specialty Measure Sets for 203 Performance Period/2025 MIPS Payment Year and Future Payment Years

Endocrinology---Proposed for Addition		
Measure Title and Description	Measure Type/Domain	Measure Steward
Screening for Social Drivers of Health: Percent of beneficiaries 18 years and older screened for food insecurity, housing instability, transportation needs, utility difficulties, and interpersonal safety.	Process/Patient Safety	Physicians Foundation
Kidney Health Evaluation: Percentage of patients aged 18-75 years with a diagnosis of diabetes who received a kidney health evaluation defined by an Estimated Glomerular Filtration Rate (eGFR) AND Urine Albumin-Creatinine Ratio (uACR) within the 12-month measurement period.	Process/Effective Clinical Care	National Kidney Foundation
Adult Immunization Status: Percentage of members 19 years of age and older who are up-to date on recommended	Process/ Community/ Population Health	National Committee for Quality Assurance

<p>routine vaccines for influenza; tetanus and diphtheria (Td) or tetanus, diphtheria and acellular pertussis (Tdap); zoster; and pneumococcal.</p>		
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Endocrinology---Proposed for Removal		
Measure Title and Description	Measure Type/Domain	Measure Steward
<p>Preventive Care and Screening: Influenza Immunization: Percentage of patients aged 6 months and older seen for a visit between October 1 and March 31 who received an influenza immunization OR who reported previous receipt of an influenza immunization.</p>	<p>Process/ Community/ Population Health</p>	<p>National Committee for Quality Assurance</p>
<p>Pneumococcal Vaccination Status for Older Adults: Percentage of patients 66 years of age and older who have ever received a pneumococcal vaccine.</p>	<p>Process/ Community/ Population Health</p>	<p>National Committee for Quality Assurance</p>
<p>Diabetes: Medical Attention for Nephropathy: The percentage of patients 18- 75 years of age with diabetes who had a nephropathy screening test or evidence of nephropathy during the measurement period.</p>	<p>Process/Effective Clinical Care</p>	<p>National Committee for Quality Assurance</p>