

AAOS Detailed Summary of CY 2023 Medicare Physician Fee Schedule Proposed Rule: What Physicians Need to Know

The Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) was released on July 7, 2022 by the Centers for Medicare & Medicaid Services (CMS). The annual payment rule sets policy for physicians participating in the Medicare program and makes updates to the Quality Payment Program. AAOS will submit formal comments to CMS and appreciates feedback from members ahead of the September 6, 2022 deadline. The final rule will likely be released in November, and the majority of the regulations will take effect on January 1, 2023. Below is a high-level description of key proposals:

CY 2023 PFS Ratesetting and Conversion Factor

- The conversion factor, which is the primary factor determining increases or decreases to overall payment rates in the physician fee schedule, will be reduced from \$34.61 to \$33.08. This conversion factor accounts for the statutorily required update to the conversion factor for CY 2023 of 0%, the expiration of the 3% increase in the PFS payments for CY 2022 as required by the Protecting Medicare and American Farmers from Sequester Cuts Act, and the statutorily required budget neutrality adjustment to account for changes in the Relative Value Units.

Payment for Medicare Telehealth Services

- CPT Codes temporarily added to the Category 3 covered telehealth services did not meet criteria to be added permanently to Category 1 and 2 and all flexibilities for Category 3 codes will end after CY 2023. If the PHE extends past 2023, the policy may be revised. Included in that decision are (1) Physical Therapy services (e.g., CPT codes 97110, 97112, 97116) which lack elements to furnish services remotely on a permanent basis after the PHE; and (2) Audio only telephone E/M Services (CPT codes 99441, 99442, and 99443), which are reimbursed equal to the amount of in-person visits during the PHE, which will end after the PHE. CMS maintains that after the PHE expires all telehealth services, other than mental health care, must have two-way, audio/video communications for telehealth services. (76)

Valuation of Specific Codes

- CMS proposes valuations for newly created and revised CPT codes as part of maintenance of the PFS. The proposed recommendations of interest are:
- **Removal of Sutures or Staples (15851, 158X1, 158X2)**
CMS is proposing the RUC recommended work RVU of 1.10 for CPT code 15851 (Removal of sutures or staples requiring anesthesia (ie, general anesthesia, moderate sedation)). CMS is not proposing any work RVU refinements for codes 158X1 (Removal of sutures **OR** staples not requiring anesthesia (List separately in addition to E/M code) and 158X2 (Removal of sutures **AND** staples not requiring anesthesia (List separately in addition to E/M code) as they were valued by the RUC as PE-only codes.
- **Arthrodesis Decompression (22630, 22632, 22633, 22634, 63052, 63053)**
CMS disagrees with the RUC recommended work RVUs of;
 - 22.09 for code 22630 (Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar), proposing a work RVU of 20.42
 - 26.80 for code 22633 (Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar), proposing a work RVU 24.83
 - 7.96 for code 22634 (Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment (List separately in addition to code for primary procedure)) proposing a work RVU 7.30
 - 5.70 for code 63052 (Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis,

lumbar; single vertebral segment (List separately in addition to code for primary procedure), proposing the current work RVU of 4.25

- 5.00 for code 63053 (Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure), proposing the current work RVU of 3.78
- CMS agrees with the proposed RUC recommended maintenance of the current work RVU of 5.22 for code 22632 (Arthrodesis, posterior interbody technique, including laminectomy an/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace (List separately in addition to code for primary procedure) as there were no surveyed time changes.
- **Total Disc Arthroplasty (22857, 228XX)**
CMS is proposing to maintain the RUC-recommended work RVU of 27.13 for code 22857 and contractor pricing for code 228XX for CY 2023. These codes were initially surveyed for the January 2022 RUC Meeting, but the specialty societies indicated that the survey results were erroneous and requested resurveyed. CMS will revisit the valuations of these codes when they receive the April 2022 RUC recommendations.
- **Insertion of Spinal Stability Distractive Device (22869, 22870)**
CMS is proposing to accept maintenance of the current work RVUs of 7.03 for code 22869 (Insertion of interlaminar/interspinous process stabilization/distractive device, without open decompression or fusion, including image guidance, when performed, lumbar; single level) and current work RVUs of 2.34 for code 22870 (Insertion of interlaminar/interspinous process stabilization/distractive device, without open decompression or fusion, including image guidance when performed, lumbar; second level (List separately in addition to code for primary procedure).
- **Knee Arthroplasty (27446, 27447)**
CMS is proposing to maintain the RUC-recommended work RVU of 17.13 for code 27446 (Arthroplasty, knee, condyle and plateau; medial OR lateral compartment) and the work RVU of 19.60 for code 27447 (Arthroplasty, knee, condyle and plateau; medial AND lateral).
- **Lumbar Laminotomy with Decompression (63020, 63030, 63035)**
CMS disagrees with the RUC recommended work RVUs of;
 - 15.95 for code 63020 (Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical), proposing a work RVU of 14.91
 - 63030 (Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar), proposing a work RVU of 12.00
 - 63035 (Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical), proposing a work RVU of 4.00
- **Contrast X-Ray of Knee Joint (73580)**
CMS is proposing the RUC-recommended work RVU of 0.59 for code 73580 (Radiologic examination, knee, arthrography, radiological supervision, and interpretation).
- **Neuromuscular Ultrasound (76881, 76882, 76XX0)**
CMS disagrees with the RUC-recommended work RVUs of;
 - 0.90 for code 76881 (Ultrasound, complete joint (ie, joint space and peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation), proposing a work RVU of 0.54
 - 0.69 for code 76882 (Ultrasound, limited, joint or other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft-tissue mass[es]), real-time with image documentation), proposing a work RVU of 0.59
 - 1.21 for code 76XX0 (Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity), proposing a work RVU of 0.99

Hospital Inpatient or Observation Care Services (99221-99223, 99231-99236)

- CMS is proposing to accept the RUC recommendations for the following inpatient and observation E/M codes:
 - 99221 (work RVU of 1.63, intraservice time of 40 minutes, and total time of 40 minutes)
 - 99222 (work RVU of 2.60, intraservice time of 55 minutes, and total time of 55 minutes)
 - 99223 (work RVU of 3.50, intraservice time of 74 minutes, and total time of 74 minutes)
 - 99231 (work RVU of 1.0, intraservice time of 25 minutes, and total time of 25 minutes)
 - 99232 (work RVU of 1.59, intraservice time of 36 minutes, and total time of 36 minutes)
 - 99233 (work RVU of 2.40, intraservice time of 52 minutes, and total time of 52 minutes)
 - 99234 (work RVU of 2.00, intraservice time of 45 minutes, and total time of 50 minutes)
 - 99235 (work RVU of 3.24, intraservice time of 68 minutes, and total time of 76 minutes)
 - 99236 (work RVU of 4.30, intraservice time of 85 minutes, and total time of 97 minutes)

Hospital Inpatient or Observation Discharge Day Management (99238, 99239)

- CMS is proposing to accept the RUC recommendations for the following discharge day management codes:
 - 99238 (work RVU of 1.50, intraservice time of 28 minutes, and a total time of 38 minutes)
 - 99239 (work RVU of 2.15, intraservice time of 45 minutes, and a total time of 64 minutes)

Emergency Department Visits (99281-99285)

- CMS is proposing to accept RUC recommended work RVUs for four of the five codes in the emergency department visits family:
 - 99281 (wRVU 0.25)
 - 99282 (wRVU 0.93)
 - 99283 (wRVU 1.60)
 - 99285 (wRVU 4.00)
- CMS disagrees with the RUC-recommended work RVU of 2.60 for code 99284 and are proposing to maintain the current work RVU of 2.74.

Evaluation and Management (E/M) Visits

- Revised Office/Outpatient (O/O) E/M codes effective January 1, 2021, were mostly accepted by CMS, with the exception of the revisions for prolonged O/O services, over concern that overpayment may result and would impact the ability to determine the total time spent with the patient. Therefore, CMS created HCPCS add-on code G2211 and G2212 (O/O E/M visit complexity), as well as HCPCS codes for prolonged E/M care beyond the total time for the primary service (i.e. GXXX1, hospital inpatient or observation; GXXX2, nursing facility; and GXXX3 home or residence). The Consolidated Appropriations Act, 2021 imposed a moratorium on Medicare payment for these services by prohibiting CMS from making payment under the physician fee schedule for HCPCS code G2211 before January 1, 2024.
- These new HCPCS G-codes would replace prolonged services CPT codes 99356 and 99357 that will be deleted for 2023. CPT 2023 instructs users to instead report new CPT code 993X0 for prolonged E/M services on the date of an inpatient or observation or nursing facility service. Guidance from the 2023 CPT Codebook further states, "Code 993X0 is used to report prolonged total time (that is, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of an inpatient service. Prolonged total time is time that is 15 minutes beyond the time required to report the highest-level primary service." CMS does not propose to adopt CPT code 993X0, believing that the instructions for the code will lead to administrative complexity, potentially duplicative payments, and limit the ability to determine how much time was spent with the patient. CMS is instead proposing to that HCPCS prolonged service code GXXX1 can only be applied to the highest-level hospital inpatient or observation care visit codes (CPT codes 99223, 99233, and 99236), and can be used when selecting the E/M visit level based only on time. CMS is further proposing to add HCPCS codes GXXX1, GXXX2, and GXXX3 to the temporary Category 1 list for Medicare Telehealth Services.

- CMS is proposing to generally adopt the 2023 revised CPT E/M Guidelines for Other E/M visits, in which time or MDM is used to select the E/M level. However, CMS will not adopt the general CPT rule where a billable unit of time is considered to have been attained when the midpoint is passed and requires the full time within the CPT code descriptors to be met in order to select an O/O E/M visit level using time, rather than half of the descriptor time.
- According to the 2023 CPT Codebook, CPT code 993X0, which represents a 15-minute interval, would apply to for example CPT code 99223 when a practitioner reaches 90 minutes; the time represents only 15 minutes more than the codes' descriptor times. CMS disagrees with this instruction and believes that a prolonged code is only applicable after both the total time described in the base E/M code descriptor is complete and the full 15-minutes described by the prolonged code are complete as well. CMS noted the CPT instructions for CPT code 993X0 do not align with CMS payment policy. CMS is also proposing that the proposed GXXX1 would apply to both face-to-face and non-face-to-face time spent on the patient's care within the survey timeframe. For CPT codes 99223 and 99233, this would be time spent on the date of encounter.
- CMS maintains it does not recognize the term "subspecialty" and proposes amending CPT definitions of initial and subsequent services to remove the term "subspecialty".
- Split (or shared) visits refer to an E/M visit performed by both a physician and an NPP in the same group practice. In the CY 2022 PFS final rule CMS finalized a policy for E/M visits furnished in a facility setting (hospital), to allow payment to a physician for a split (or shared) visit (including prolonged visits), where a physician and NPP provide the service together (not necessarily concurrently) and the billing physician personally performs a "substantive" portion of the visit. In the non-facility (office) setting, the rules for "incident to" billing apply but are not available for services furnished in a facility setting. CMS policy has been that, for split (or shared) visits in the facility (hospital) setting, the physician can bill for the services if they perform a substantive portion of the encounter and payment is made for services furnished and billed by a physician at 100% of the PFS rate, and NPPs are paid for the services they furnish and bill for at a reduced PFS rate (85% of the PFS). CMS defined substantive portion in the CY 2022 PFS final rule and provided for billing of split (or shared) visits in certain settings and for certain patient types (new and established), as one of the following: history, or exam, or MDM, or more than half of total time. The CY 2022 PFS final rule listed for CY 2023, the definition of "substantive portion" as being more than half of total time. Ongoing concern from interested parties remain as practice patterns where the physician does not spend half or more of the time with the patient, as well as possible adjustments needed to the practice's internal processes or information systems to track visits based on time, rather than MDM. CMS is proposing to delay implementation of the definition of the substantive portion as more than half of the total time until January 1, 2024. Therefore, for visits other than critical care visits furnished in calendar year 2022 and 2023, substantive portion means one of the three key components (history, exam, or MDM) or more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

Solicitation on Global Surgical Services

- CMS is soliciting public comment on strategies for improving global surgical package valuation and paying more accurately for the global surgical packages under the Physician Fee Schedule. CMS believes that there is strong evidence suggesting that the current RVUs for global packages are inaccurate, many interested parties agree that the current values for global packages should be reconsidered, and that it is necessary to take action to improve the valuation of the services currently valued and paid under the PFS as a global surgical package.

Non-Face-to-Face/Remote Therapeutic Monitoring (RTM) Services

- In 2022, five CPT codes were created for Remote Therapeutic Monitoring and Treatment Management Services (RTM). The RTM codes include three Practice Expense (PE) only codes and two treatment management codes. In the CY 2022 PFS final rule CMS expressed concern with the RTM codes as described by the CPT and RUC, particularly the inclusion of clinical labor in codes that could be billed by nonphysician practitioners. Since the CY 2022 PFS final rule, CMS has also received communication regarding two concerns related to the clinical labor in the direct PE for the two RTM treatment management codes (98980 and 98981). (1) the inclusion of clinical labor billed by nonphysician practitioners, as Medicare

Part B does not include a member benefit for “incident to” services except for some types of qualified nonphysician practitioners (e.g. PTs, OTs, and SLPs), and (2) the requirement of direct supervision by the billing practitioner would be burdensome resulting in the and questionable use of the codes to be reported with the requirement of direct supervision. The commenters suggested that CMS develop HCPCS G codes that would allow the “incident to” clinical labor portions of the services to be furnished under general supervision of the billing physician or nonphysician practitioner, not direct supervision. Thus, for CY 2023 CMS is proposing to make the current CPT codes 98980 and 98981 codes **non-payable** by Medicare and proposing to create four new HCPCS G codes, with two codes (GRTM3, and GRTM4) that would specifically facilitate RTM services furnished by nonphysician practitioners who cannot bill under Medicare Part B for services furnished incident to their professional services. Neither of these two proposed codes would not include “incident to” activities in the PE, or clinical labor inputs in the direct PE. And created two codes allowing general supervision of auxiliary personnel (GRTM1 and GRTM2) that include clinical labor activities (incident to services such as communicating with the patient, resolving technology concerns, reviewing data) that can be furnished by auxiliary personnel under *general* supervision. These two new G codes, GRTM1 and GRTM2, will include physician work and direct PE inputs as currently described in CPT codes 98980 and 98981 but will allow general supervision of the clinical labor found in the direct PE inputs.

- In the CY 2022 PFS final rule, CMS finalized a policy that permitted therapists and other qualified healthcare practitioners to bill the RTM codes, and stated that where the practitioner’s Medicare benefit does not include services furnished incident to their professional services, the services described by the codes must be furnished *directly* by the billing practitioner or, in the case of a PT or OT, by a therapy assistant under the billing PT’s or OT’s supervision, and that these practitioners could bill CPT codes 98980 and 98981 even when the practitioner’s Medicare benefit category did not include services furnished incident to their professional services as long as the services were furnished *directly* by the billing practitioner.
- CMS is seeking comment about RTM devices that are used to deliver services that meet the “reasonable and necessary” standard and information related to the types of data collected using RTM devices. (402)

Geographic Practice Cost Indices (GPCI)

- Section 1848(e)(1)(C) of the Act requires CMS to review and, if necessary, adjust the GPICs at least every 3 years. If more than 1 year has elapsed since the date of the last previous GPCI adjustment, the adjustment to be applied in the first year of the next adjustment shall be 1/2 of the adjustment that otherwise would be made. Therefore, since more than 1 year has passed since the previous GPCI update was implemented in CY 2020 and 2021, CMS is proposing to phase in 1/2 of the proposed GPCI adjustment in CY 2023 and the remaining 1/2 of the adjustment for CY 2024. (352)

Determination of Malpractice Relative Value Units (RVUs)

- Similar to the update to the GPCI, CMS is required to review and update (if necessary) the malpractice (MP) RVUs at least every 3 years. The MP RVUs that CMS is proposing for CY 2023 used updated MP premium data obtained from State insurance rate filings.
- The MP RVUs that CMS are proposing were calculated using four data sources: 1) MP premium data presumed to be in effect as of December 31, 2020; 2) CY 2020 Medicare payment and utilization data; 3) Higher of the CY 2022 final work RVUs or the clinical labor portion of the direct PE RVUs; and 4) CY 2022 MP GPICs. CMS used the higher of the CY 2022 final work RVUs or clinical labor portion of the direct PE RVUs in their calculation to develop the CY 2023 proposed MP RVUs while maintaining overall PFS budget neutrality.
- CMS is proposing methodological improvements to the development of MP premium data by 1) Improving their current imputation strategy to develop a more comprehensive data set when CMS specialty names are not distinctly identified in the insurer filings; and 2) utilizing a true MP risk index as opposed to derived risk factors when calculating MP RVUs. (387)

Rebasing and Revising the Medicare Economic Index (MEI)

- CMS is soliciting comments on their proposal to rebase and revise the MEI cost share weights which measures the input price pressures of providing physician services. CMS is proposing a new methodology which allows for use of data from the

U.S. Census Bureau NAICS 6211 Office of Physicians. CMS believes that the data is more reflective of the current market conditions of physician ownership practices and will allow for the MEI to be updated on a more regular basis.

Medicare Shared Savings Program

- Several of the proposals CMS is making in this proposed rule are expected to advance equity within the Shared Savings Program. Additionally, many of the proposals are a result of CMS's efforts to align policies under the Shared Savings Program and under the Innovation Center's ACO models. With these proposals, CMS has provided some examples of formative tools to best serve underserved populations, while making note that there are multiple ways to improve population health management and support the provision of accountable care for all. CMS recognizes this will also vary by ACO. With that, CMS is providing three focus points:
 - Increased Staffing
 - "Hiring nurse case, managers or other relevant support staff to implement screening for SDOH." (633)
 - SDOH Strategies
 - "Examples include developing or securing transportation services; housing-related services to address housing insecurity or homelessness, home or environmental modifications to support a healthy lifestyle, legal aid services to help patients' address social needs, employment-related services, food-related services, utilities-related supports, services to support personal safety, services to reduce social isolation, services to help patients cope with or address financial strain or poverty, patient caregiver supports, providing remote access technologies, telemonitoring, and meals; ensuring individuals are able to access culturally and linguistically tailored, accessible health care services and supports that meet their needs, partnering with community-based organizations such as Area Agencies on Aging or Centers for Independent Living to address SDOH needs; or implementing systems to provide and track patient referrals to available community-based social services that assess and address social needs, as well as enable coordination and measurement of health and social care across the community where beneficiaries reside. CMS reserves the right to review any SDOH strategies and require that the ACO make changes as a result of that review." (633)
 - Health Care Provider Infrastructure
 - "Examples include investment in certified electronic health record technology (CEHRT) (including system enhancements and upgrades), connections to clinical data registries and networks that support health information exchange across disparate providers and systems involved in patient care, integration of ACO participant systems including tools to share and analyze operational and quality data, remote access technologies, telemonitoring, screening tools, case management or practice management systems to improve care coordination operations across the health and social care continuum, physical accessibility improvements, and tools to further integrate behavioral health or dental services into primary care settings." (644)

Updates to the Quality Payment Program

- CMS is proposing limited updates to traditional Merit-Based Incentive Payment System (MIPS) and continuing to develop new MIPS Value Pathways (MVP). There are several proposals on Advanced Alternative Payment Models (APM) policy. Notable proposals include a request for information on CMS response to the MACRA instituted change in APM incentive payment a 5% lump sum APM Incentive Payment awarded to Qualifying APM Participants (QPs) in payment years 2019-2024 to having a 0.75% Conversion Factor update available to them in payment years 2026 onward. (There is no APM incentive authorized under MACRA for the 2023 performance year/2025 payment year.) CMS is also requesting for feedback on whether third party intermediaries (e.g., Qualified Clinical Data Registries (QCDRs)) should have the flexibility

to choose the measures they will support within the MVP. To align policies across all programs, CMS included a MIPS health equity RFI on the development and implementation of health equity measures for the quality performance category. CMS is also asking for feedback on considering a change in QP determination: from the APM entity to the individual level to encourage specialty participation in Advanced APMs. (1099)

- As CMS continues to move forward with MVP implementation, they are continuing to seek feedback on ways to better align clinician experience between MVP's and APM's, and to ensure that MVP reporting can serve as a bridge to APM participation. CMS is currently requesting feedback on the following questions as described in section IV.A 7.b. (1):
 - "How should we use MVPs to obtain more meaningful performance data from both primary care and specialty clinicians and drive improvements for APP reporters and APM participants? What are the associated pros and cons for the suggested solution(s)?"
 - "How should we better align clinician experience with MVPs and APMs, and ensure that MVP reporting serves as a bridge to APM participation?"
 - "How should we best limit burden and develop scoring policies for APM participants in multispecialty groups who choose to participate in MVPs and report specialty care performance data? Should we require APP participants to focus on those clinicians who work in the associated quality measurement clinical area and require subgroup reporting of relevant MVPs for others? Should we develop a process for a composite score that incorporates both APM measures and other MVP specialty measures?"
 - "What other policy options for MIPS specialty clinician performance data reporting should we consider?" (1130)
- CMS is proposing five new MVPS:
 - Advancing Cancer Care
 - Optimal Care for Kidney Health
 - Optimal Care for Neurological Conditions
 - Supportive Care for Cognitive-Based Neurological Conditions
 - Promoting Wellness
- CMS is proposing to include the MIPS measure "Q039: Screening for Osteoporosis for Women Aged 65-85 Years of Age: This MIPS quality measure assesses women, 65-85 years of age, who have ever received a dual-energy x-ray absorptiometry (DXA) test to evaluate for the disease osteoporosis." (with the "Promoting Wellness" MVP. CMS reviewed the MIPS quality measure inventory and believed this quality measure provide a meaningful and comprehensive assessment of the clinical care for clinicians who specialize in providing preventive care: 2048)
- CMS is also proposing previously finalized MVP modifications for the CY 2023 performance period/ 2025 MIPS payment year. CMS is "proposing to modify the previously finalized Improving Care for Lower Extremity Joint Repair MVP to remove IA_PSPA_6: Consultation of the Prescription Drug Monitoring Program. This proposal is being made in conjunction with the proposal to remove this improvement activity from the MIPS Improvement Activity Inventory and is contingent on that proposal being finalized as proposed. In addition, CMS is proposing to add IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation to this MVP. CMS is proposing to add the Promoting Interoperability performance category ONC Direct Review attestation requirement to this MVP." (2061)

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