AAOS
American Association of Orthopaedic Surgeons

AAOS Executive 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. This rule has provisions that would significantly expand access to behavioral health services, Accountable Care Organizations (ACOs), cancer screening, and dental care — particularly in rural and underserved areas. These proposed changes play a key role in the Biden-Harris Administration's Unity Agenda. 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 Medicare 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 public health emergency (PHE) extends past 2023, the policy may be revised. (76)

Valuation of Specific Codes

- CMS proposes valuations for newly created and revised CPT codes as part of maintenance of the PFS. Proposals of interest for orthopaedic surgery are (117):
    - *Removal of Sutures or Stables (15851, 158X1, 158X2)*
    - *Arthrodesis Decompression (22630, 22632, 22633, 22634, 63052, 63053)*
    - *Total Disc Arthroplasty (22857, 228XX)*
    - *Insertion of Spinal Stability Distractive Device (22869, 22870)*
    - *Knee Arthroplasty (27446, 27447)*
    - *Lumbar Laminotomy with Decompression (63020, 63030,63035)*
      Contrast X-Ray of Knee Joint (73580)
    - *Neuromuscular Ultrasound (76881, 76882, 76XX0)*

Evaluation and Management (E/M) Visits

- CMS is proposing to generally adopt the 2023 revised CPT E/M Guidelines for Office/Outpatient (O/O) E/M visits, in which time or medical decision making (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 outpatient office O/O E/M visit level using time.
- 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 non-physician practitioner (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. (297)

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 relative value units (RVU) 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. (49)

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

- 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 comments 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 GPCIs 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 (MP) Relative Value Units (RVUs)

- 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. (448)

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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 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 and why.
- 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)
- CMS is proposing several new MIPS Value Pathways (MVP) but not relevant for orthopaedic surgery, in general. However, CMS is proposing some modifications to the Lower Extremity Joint Replacement (LEJR) MVP for the CY 2023 performance period/ 2025 MIPS payment year. CMS is "proposing to remove IA_PSPA_6: Consultation of the Prescription Drug Monitoring Program." This proposal is being made in conjunction with their 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.

Read the complete rule…