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The Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2023 Physician Fee Schedule Final Rule on November 1. This final rule adopts a conversion factor that reflects a 4.5% decrease from the CY 2022 rate. Immediately after the final rule was released, industry groups reignited calls for Congressional intervention, claiming that the rate cut will have a negative impact on Medicare patients' access to care as physician practices continue to face rising costs. Below is a recap of the key provisions contained in the final rule, as well as other relevant factors that will impact overall Medicare reimbursement.

Conversion Factor

Medicare reimbursement for professional services is generally determined by multiplying the applicable relative value unit (RVU) amounts for billed services by the conversion factor in place on the date the service was rendered (adjusted for the specific locality). Typically, the conversion factor does not change significantly from year to year, given that CMS is required by law to maintain budget neutrality. However, the conversion factor decreased substantially in 2021 in response to significant increases in Work RVUs (wRVUs) for many office visits and similar services that were determined to be undervalued historically. Initially, the 2021 conversion factor was set to be $32.41, but Congress intervened and approved a 3.75% adjustment, which resulted in only a 3.3% reduction from 2020 rather than 10.2%. Similarly, the conversion factor for 2022 was set to be $33.60 based on the fee schedule issued by CMS (a 3.7% decline from 2021), but again the rate was increased at the last minute as a result of legislation that provided a 3% adjustment. However, this legislation stipulated that CY 2023 rate needed to be determined by CMS without the benefit of the 3% increase. The anesthesia conversion factor has followed a similar storyline.

To recap, below is a summary of the Conversion Factor (after legislative adjustments) and the Anesthesia Conversion Factor for the last several years:

Year	Conversion Factor	% Change	Anesthesia Conversion Factor	% Change
2019	$ 36.0391		$ 22.2730	
2020	$ 36.0896	0.1%	$ 22.2016	(0.3%)
2021	$ 34.8931	(3.3%)	$ 21.5600	(2.9%)
2022	$ 34.6062	(0.8%)	$ 21.5623	0.0%
2023	$ 33.0607	(4.5%)	$ 20.7191	(3.9%)
Cumulative Change: 2019 - 2023	$ (2.98)	(8.3%)	$ (1.55)	(7.0%)

Sequestration Impact

It should be noted that the conversion factor reflected in the Medicare Physician Fee Schedule (PFS) is prior to any reduction for sequestration. A 2% Medicare sequestration cut stems from a 2011 law that required across-the-board spending cuts for the federal government from fiscal year (FY) 2013 to FY 2030. Under this law, Medicare cuts cannot exceed 2%. Subsequent legislation suspended the application of sequestration to Medicare from May 1, 2020 through December 31, 2021, to provide relief to providers during the COVID-19 pandemic. The same legislation that increased the 2022 PFS conversion factor also further delayed sequestration and invoked a phased-in return. Accordingly, there was no sequestration adjustment for services rendered January 1 through March 31, 2022. A 1% reduction resumed from April 1 through June 30, 2022, with the full 2% cut resuming effective July 1, 2022. To make up for the moratorium, the sequestration adjustment will increase to 2.25% from October 1, 2029 to March 31, 2030, and to 3% from April 1, 2030 to September 30, 2030. The sequestration adjustment only applies to the portion of the payment made by Medicare and excludes the patient share.

In addition to sequestration, the Statutory Pay-As-You-Go Act ("PAYGO") was enacted in 2010 and requires spending cuts across the federal government if legislation enacted in a year results in a deficit increase. Medicare cuts resulting from this law cannot exceed 4%. To date, PAYGO has been waived by Congress to avoid cuts going into effect, but it is currently set to resume effective January 1, 2023.

With physician services provided to Medicare beneficiaries in 2023 subject to both the 2% sequestration and 4% PAYGO cuts, the actual reimbursement will be around a 10% reduction from pay rates in effect for the first quarter of 2022.

Other Provisions

The 2023 PFS Final Rule contains additional provisions that impact billing and reimbursement for a variety of services. Key components are recapped below.

Split/Shared Visits

The 2022 PFS final rule contains phased-in changes for billing inpatient split/shared visits. Split/Shared visits are those inpatient E&Ms where the service is jointly provided by a combination of a physician and a non-physician provider (NPP). The 2022 PFS final rule required that beginning in 2023 such visits must be billed under the provider number of the individual providing more than half of the total visit time. The 2023 PFS Final Rule delays implementation of that rule until 2024, consistent with the Proposed Rule that was issued by CMS in July. Instead, billing for 2023 will be the same as 2022, which allows a choice in determining which clinician provided the "substantive portion" of the visit: If the physician performs the history, physical exam, or medical decision-making, or spends more than half the total time with the patient, the visit may be billed under the physician's provider number. Otherwise, it must be billed under the NPP's number, which results in a 15% reduction to the reimbursement rate.

Telehealth Services

There has been a great deal of attention regarding how telehealth services will be treated after the public health emergency (PHE) ends. During the pandemic, CMS implemented several policy changes to allow more widespread usage of, and reimbursement for, telehealth services. Legislation passed earlier this year allowed for current rules to remain in effect for 151 days after expiration of the PHE. The PHE was most recently extended on October 13, and is currently set to expire January 11, 2023.

The 2023 PFS Final Rule incorporates the 151-day extension of telehealth services as prescribed by the *Consolidated Appropriations Act, 2022*, and also makes certain services temporarily available during the PHE available throughout 2023 on a Category 3 basis before determining whether they should be permanently added to the Medicare telehealth services list. Category 3 is a category for services that were added to the approved list of telehealth services during the pandemic, and "for which there is likely to be clinical benefit when furnished via telehealth, but there is not yet sufficient evidence available to consider the services for permanent addition under the Category 1 or Category 2 criteria." In addition, the final rule permanently adds the following services to the Medicare Telehealth Services List on a Category 1 basis:

HCPCS	Short Descriptor
G0316	Prolonged inpatient or observation services by physician or other QHP
G0317	Prolonged nursing facility services by physician or other QHP
G0318	Prolonged home or residence services by physician or other QHP
G3002	Chronic pain treatment monthly bundle
G3003	Addition 15m pain management

Source - CMS-1770-F, Table 13: Services Finalized for Permanent Addition to the Medicare Telehealth Services List on a Category 1 Basis.

However, the final rule also includes a list of services that will be removed from the Medicare Telehealth Services List after 151 days following the expiration of the PHE. These include services such as eye exams for new patients, initial observation care, initial hospital care, initial nursing facility care, home visits for new patients, and initial neonatal or pediatric critical care.[1]

In addition, CMS finalized its proposal to allow providers to continue to use place of service indicators that would have been reported had the service been furnished in person, through either the end of 2023 or the end of the year in which the PHE ends. These claims will require the modifier "95" modifier to identify them as telehealth services. In the event the telehealth service is provided via audio-only technology (rather than audio-visual), a modifier of "93" should be used.

For CY 2023, the payment amount for Telehealth Originating Site Facility Fee (HCPCS code Q3014) is $28.64, up 3.8% from $27.59 in 2022.

Behavioral Health

To address the increased need for mental health services, the 2023 PFS Final Rule creates a a new behavioral health integration service code, G0323, that would allow clinical psychologists or clinical social workers to account for monthly care integration when such individual is "serving as the focal point of care integration." Further, this code was added to the list of designated care management services for which general supervision is allowed. In addition, the final rule allows certain behavioral professionals (e.g., licensed professional counselors and licensed marriage and family therapists) to provide care under general rather than direct supervision of a physician or NPP when their services are provided incident to the services of a physician or NPP.

[1] CMS 1770-F, Table 14: Services to be Removed from the Medicare Telehealth Services List After 151 Days Following End of the PHE.

Chronic Pain Management

CMS has added new HCPS codes for chronic pain management and treatment, consistent with the proposed rule. These codes include a bundle of services typically rendered during a month that would allow for a more holistic approach to treating chronic pain. The rule defines chronic pain as "persistent or recurring pain lasting longer than three months." The new codes are G3002 (chronic pain management and treatment, monthly bundle) and G3003 (each additional 15 minutes of pain management and treatment). The first time G3002 is billed, the provider must see the beneficiary in person in a clinical setting. G3003 may be billed for each additional 15 minutes of care, an unlimited number of times (as medically necessary). These codes may be billed on the same day as an evaluation and management (E/M) service, so long as all requirements to bill each service are met.

Evaluation & Management Visits

CMS has adopted the CPT Editorial Panel's changes to inpatient and observation care codes, which deleted seven observation care codes and revised nine other codes to create a single set of codes for inpatient and observation care. The codes may be selected based on either medical decision-making or time. The final rule also adopts a new code, G0316, for prolonged hospital inpatient and observation care services. This code may only be used when selecting the E/M visit code based on time, and may only be applied to the highest-level E/M visit code.

Additionally, CMS is adopting the CPT Editorial Panel's revisions to merge the code set for domiciliary, rest home, or custodial care services beginning January 1, 2023. These codes also may be selected based on total practitioner time or medical decision-making. A new code, G0318, may be used for a prolonged home or residence visit.

Audiology Services

The 2023 PFS Final Rule would allow audiologists to provide certain services for non-acute hearing conditions on an annual basis without a physician referral. These services include exams for the purpose of prescribing, fitting, or changing hearing aids, but specifically exclude balance assessments for patients with disequilibrium. However, in a change from the proposed rule, these services provided without a physician referral will be billed using the applicable CPT code and a new modifier (modifier AB) rather than being billed under a G-code (GAUDX). The final rule notes that this "necessitates multiple changes to our claims processing systems, which will take some time to operationalize, possibly until mid-year 2023."

Colorectal Cancer Screening

The PFS Final Rule reduces the minimum age for colorectal cancer screening tests that currently include a minimum age of 50 to 45, in line with a recently revised recommendation by the U.S. Preventive Services Task Force. A screening colonoscopy will continue to not have a minimum age limitation. Additionally, a follow-on screening colonoscopy after a positive result on a non-invasive stool-based colorectal cancer screening test covered by Medicare will also be covered as a screening test rather than a diagnostic test as is the current practice. This is an effort to encourage more patients to obtain the appropriate follow-up test, and to acknowledge recent evidence-based recommendations that the follow-up test is necessary "for the screening benefits to be achieved." This is an important distinction since Medicare covers screening tests at 100% while diagnostic tests require cost-sharing by the beneficiary.

Dental & Oral Health Services

CMS is finalizing a clarification and codification of its payment policy for medically necessary dental services. For 2023, dental exams and necessary treatment performed as part of a comprehensive workup prior to organ transplant surgery or prior to cardiac valve replacement or valvuloplasty procedures will be eligible for payment under Medicare Parts A and B. Beginning in 2024, dental services performed as part of a comprehensive workup prior to or contemporaneously with treatment for head and neck cancers will also be covered by Medicare.

Further, CMS is finalizing amendments to its regulations to provide that "dental services that are inextricably linked to, and substantially related and integral to the clinical success of, a certain covered medical service" are eligible for payment under Medicare Parts A and B for "dental services that occur within the inpatient and outpatient setting, as clinically appropriate."

Specifically, CMS clarified that the following dental services are examples of dental services that should be covered under Medicare Parts A and B:

- Dental or oral exam as part of a comprehensive workup prior to renal organ transplant surgery;
- Reconstruction of a dental ridge performed as a result of and at the same time as the surgical removal of a tumor;
- Extraction of teeth to prepare the jaw for radiation treatment of neoplastic disease; and
- Stabilization or immobilization of teeth in connection with the reduction of a jaw fracture and dental splints only when used in conjunction with covered treatment of a covered medical condition, such as dislocated jaw joints.

To qualify for payment under these provisions, the dentist providing the services must be in communication with the physician or NPP treating the primary medical condition. "If there is no exchange of information, or integration, between the medical professional … in regard to the primary medical service and the dentist in regard to the dental services, then there would not be an inextricable link between the dental and covered medical services within the meaning of the regulation." The final rule will also allow payment for ancillary services in connection with covered dental services, such as x-rays, anesthesia administration, use of an operating room, or other facility services.

CMS did not finalize its proposal to provide payment for dental services provided prior to initiation of immunosuppressant therapy, joint replacement surgeries, or other surgical procedures . It was determined that further time is needed to determine whether there is an "inextricable link" between dental services and these procedures.

Clinical Lab Fee Schedule

The 2023 PFS Final Rule increases the general specimen collection fee from $3.00 to $8.57 for all specimens collected in a single patient encounter. Additionally, this fee will be increased by $2.00 for specimen collection from a Medicare beneficiary in a SNF or on behalf of a home health agency.

Medicare Shared Savings Program

The 2023 PFS Final Rule also addresses proposed changes to the Medicare Shared Savings Program in an effort "to advance CMS' overall value-based care strategy of growth, alignment, and equity." The changes are in large part a response to recent trends that indicate the program as not as effective as it could be. In particular, growth in the accountable care organizations (ACOs) has stagnated, and certain populations are underrepresented in the program. Accordingly, the proposed changes seek to incentivize increased participation, even for providers who require significant up-front investment.

One significant change that was finalized by CMS is the introduction of advance investment payments for ACOs that are new to the Shared Savings Program and identified as being low revenue and inexperienced with performance-based risk Medicare ACO initiatives. This would allow for a one-time fixed payment of $250,000 and quarterly payments for the first two years of the 5-year agreement period. These advance payments will be recouped when the ACO begins to achieve shared savings in the current agreement period and, if any balance remains, in the subsequent agreement period. If no shared savings are achieved, the advance payments will not be recouped, unless the ACO terminates during the agreement period. The advance payments would enable eligible providers to invest in appropriate infrastructure, increase staffing, or provide care for beneficiaries, which may include addressing social determinants of health. The initial application cycle will occur during 2023, with a program start date of January 1, 2024.

The final rule also allows for inexperienced ACOs to utilize a one-sided risk model for the initial five-year agreement, with a possibility for an additional two years of one-sided risk before transitioning to full risk model. Additionally, CMS is finalizing modifications to the benchmark methodology. These include:

- Incorporating a prospective, external factor in growth rates to update the historical benchmark;
- Adjusting ACO benchmarks to account for prior savings;
- Reducing the impact of the negative regional adjustment;
- Calculating county-level fee-for-service expenditures to reflect differences in prospective assignment and preliminary prospective assignment with retrospective reconciliation;
- Improving the risk adjustment methodology to better account for medically complex, high-cost beneficiaries and guard against coding initiatives;
- Expansion of eligibility criteria to allow increased opportunities for low revenue ACOs to share in savings; and
- Ongoing consideration of concerns about the impact of the COVID-19 PHE on ACO's expenditures.

Another modification to the Shared Savings Program that was implemented in the final rule is to change from an all-or-nothing approach to eligibility for shared savings to a sliding scale approach, beginning January 1, 2023. Also, a health equity adjustment could provide bonus points for ACOs who achieve high quality measures while serving a higher proportion of underserved or dually eligible beneficiaries. Finally, the final rule includes modifications intended to reduce the administrative burden for participating ACOs.

What's Next?

While some of the provisions contained in the 2023 PFS Final Rule were well received, the overall response from the physician community since the proposed rule was released has been frustration that the decreased reimbursement resulting from the reduced conversion factor will be inadequate, particularly in light of the current economic climate. With continuing inflation and widespread labor shortages, practices are already struggling to maintain financial stability, even before the Medicare decrease – which will be further compounded by the return of sequestration and the introduction of PAYGO cuts. Practices must offer competitive compensation levels to attract and retain their clinical support staff in an era when many are choosing to leave the profession. Administrative support staff costs are increasing as well, as many lower paid positions are getting lured to jobs in other industries. Meanwhile, supply costs continue to rise and physician practices must also expend resources to ensure they remain compliant with all regulatory requirements.

Many physician advocacy organizations have been lobbying for Congress to intervene and provide a long-term fix for the broken Medicare Physician Fee Schedule system. The "Supporting Medicare Providers Act of 2022" (H.R. 8800) was introduced in the House on September 13, and currently has 72 cosponsors (54 Democrats and 18 Republicans). This bill seeks to extend the payment increase implemented in the "Protecting Medicare and American Farmers from Sequester Cuts Act," currently set to expire at the end of 2022, through the end of 2023. More than 100 industry organizations signed a letter in support of this legislation, referencing it as "an essential step toward providing clinicians with financial stability and ensuring patients have access to critical services our members provide." Additionally, these organizations are seeking long-term changes to the physician payment system, noting that it is the "only payment system within Medicare without an annual inflationary update." To date, there has been no further legislative activity relating to this bill, nor have any related bills been introduced.

"…H.R. 8800 [is] an essential step toward providing clinicians with financial stability and ensuring patients have access to critical services our members provide."

We expect lobbying efforts to intensify as we move closer to the end of the year. Unfortunately, it is likely that any legislative relief that may arise will once again, for the third year in a row, come at the last minute. The conversion factor adjustment for 2021 was included in legislation that was signed into law December 27, 2020, while the relief for 2022 was included in legislation enacted December 10, 2021. There is a great deal of uncertainty with regard to what legislation may get passed during the lame duck session following the upcoming midterm elections. However, due to the broad implications it is possible that this issue could garner enough bipartisan support to gain approval.

JTaylor's healthcare consulting team includes a group of professionals who specialize in physician practice dynamics, as well as individuals who focus on strategy and operations. We will continue to monitor developments related to Medicare payment rates and sequestration. Our team can also support you from a strategic perspective as you plan for reduced reimbursement. To find out more or to contact a member of our team, please visit our website.

Resources:

- Fact Sheet: CY 2023 Physician Fee Schedule Final rule
- Fact Sheet: Medicare Shared Savings Program
- CY 2023 Physician Fee Schedule and Quality Payment Program final rule
- H.R. 8800 – Supporting Medicare Providers Act of 2022