CMS Releases 2023 Medicare Physician Fee Schedule Proposed Rule

2023 Conversion Factor

The proposed 2023 conversion factor has been set at **$33.07**, a decrease of -$1.54 compared to the 2022 conversion factor of $34.61. You may recall that the 2022 conversion factor included a one-year +3% bump to offset the finalized 2022 CF of $33.58 to mitigate cuts related to revaluation of evaluation and management (E&M) codes.

The proposed Anesthesia conversion factor has been set at **$20.72**, a decrease of -$.84 compared to the 2022 conversion factor of $21.56.

The conversion factor is an important element of the payment formula used to determine the Medicare-allowed payment amount for a particular physician service. The new conversion factors were determined by first removing the 3% increase enacted by the Protecting Medicare and American Farmers from Sequester Cuts Act, and then applying this year's budget neutrality update of -1.55% which reflects changes to relative value units (RVUs) for 2023.

Due to the reduction in the CF, the anticipated decrease to Medicare reimbursement for 2023 could be approximately -4% to -5%. Real-world impact depends heavily on case-mix and location such as differences between facility and non-facility settings.

Additional reductions to Medicare reimbursement, separate from the fee schedule, should also be accounted for in 2023. For example, Medicare has restored the -2% sequester reduction as required by the Budget Control Act of 2011. This cut was suspended during the height of the public health emergency, partially resuming in April of 2022 (-1%). This -2% sequester cut, fully restored in July of 2022, is not incorporated into the conversion factor and would be a separate decrease to reimbursement when estimating revenue for 2023.

In addition, the passage of the American Rescue Plan triggered a different statutory budget control measure referred to as a PAYGO (pay as you go) cut. This -4% PAYGO cut looks to be on the horizon for 2023 unless congress intervenes to waive the requirement, as they have done consistently when PAYGO cuts have been triggered in the past. For more details, CLICK HERE.

Appropriate Use Criteria (AUC) Mandate

As directed by the Protecting Access to Medicare Act (PAMA) the AUC mandate requires ordering physicians to consult a qualified clinical decision support (CDSM) tool when ordering advanced imaging services (MRI/PET/CT/Nuclear Medicine) for Medicare beneficiaries in outpatient settings.

January 1st, 2023 was when the program the expected start date of the program's 'penalty phase' which denies reimbursement for furnishing provider claims lacking AUC documentation.

However, separate from the proposed rule, CMS made the following announcement:

NOTICE: The payment penalty phase will not begin January 1, 2023 even if the PHE for COVID-19 ends in 2022. Until further notice, the educational and operations testing period will continue. CMS is unable to forecast when the payment penalty phase will begin.

CMS lacks the authority to fundamentally change the requirements of the program, requiring congressional intervention to alter the contents of the original PAMA law. There is no updated timeframe for the implementation of the AUC program at this time but Advocate will continue to provide updates as more information is available.

Colorectal Cancer Screening Coverage

CMS has proposed to update coverage of colorectal cancer screening services to align with the updated United States Preventive Services Task Force (USPSTF) recommendation to begin screening at age 45 rather than age 50. However, CMS did not discuss adding reimbursement for CT colonography within their proposals to expand coverage.

Level 2 Physician Supervision Via Audio/Video Communication

CMS announced that physician presence to directly supervise Level 2 diagnostic test (contrast studies) virtually using real-time video/audio communications technology, currently permitted due to the public health emergency, will not be extended. After December 31 of the year in when the PHE ends, the pre-PHE rules for direct supervision at would apply presuming CMS does not alter this proposal when issuing the final rule for 2023.

TeleHealth

CMS proposals for TeleHealth codify requirements of the Consolidated Appropriations Act of 2022 (CCA) within the fee schedule for 2023. The CCA extends key flexibilities for telehealth for **151 days beyond** the end of the public health emergency, specifically:

- Allowing telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home,
- Allowing certain services to be furnished via audio-only telecommunications systems, and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services.
- Delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.

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

Comments on the Proposed Rule are open until September 7, 2022.

As always, ADVOCATE will keep you up to date on this and all issues impacting medical groups as they become available.