CMS Releases Final Medicare Physician Fee Schedule for 2023

2023 Conversion Factor

The 2023 conversion factor has been set at **$33.06**. This is a decrease of -$1.55, or approximately 4.5% compared to the 2022 conversion factor of $34.61. CMS did not deviate from the rate proposed earlier this year. The 2023 CF change accounts for the expiration of the one-year +3% bump to the CF, which partially offset the changes to the finalized 2022 CF – which was originally slated to be $33.58. It also mitigated cuts related to revaluing of evaluation and management (E&M) codes finalized before the COVID PHE.

The Anesthesia conversion factor has been set at **$20.60**, a decrease of -$.96 compared to the 2022 conversion factor of $21.56. This is slightly lower than the initial proposal of $20.70.

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 in 2022, and then applying this year's budget neutrality update of -1.60% which reflects changes to relative value units (RVUs) for 2023.

Real-world impact of this update 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 planning for 2023. For example, on July 1, 2022, Medicare restored the full -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%) and fully restored in July of 2022. This 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.

Legislation was also introduced in the House of Representatives in September that would provide another one-year temporary increase, in this case +4.42%, to the 2023 CF. Although industry calls to address PAYGO cuts have increased in recent weeks, there has not been legislation introduced to that would waive or delay the cuts from being implemented in 2023.

Appropriate Use Criteria (AUC) Mandate

CMS announced a delay to the Appropriate Use Criteria Mandate in tandem with the release of the proposed rule for 2023. There has not been any updates or mention of the AUC program with the release of the final rule.

The following notice has been placed on the program's landing page:

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 finalized the proposal 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. Additionally, the definition of colorectal cancer screening has been expanded to include a follow-up screening colonoscopy after a positive stool-based screening test.

CMS declined comments to include CT colonoscopy within it's definition, stating it was outside the scope of rulemaking.

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. There were no modifications made within the final rule, thus the pre-PHE rules for direct supervision at will apply after December 31 of the year in when the PHE ends.

TeleHealth

CMS proposals for TeleHealth codified 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.

CMS finalized their proposal to begin using modifier “93” (rather than modifier “”95”), along with the appropriate place of service (POS) indicator on a claim, to indicate that a telehealth service was conducted via audio only.

In response to comments related to payment stability in the postPHE period, CMS reiterated that Medicare telehealth services will continue to maintain payment as if the service been furnished in-person through the latter of the end of CY 2023 or the end of the calendar year in which the PHE ends.

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