2023 Medicare Physician Fee Schedule Final Rule: Regulatory Changes and Updates to Physician Payment System

Each year, the Centers for Medicare & Medicaid Services (CMS) issues regulations that impact the reimbursement of physicians. On November 1, 2022, CMS issued a final rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule in 2023. The final rule illustrates the importance of the AAN's regulatory advocacy efforts on behalf of neurologists and their patients. The AAN previously submitted 50 pages of detailed comments in response to the various proposals made by CMS in July.

Due to budget neutrality requirements, CMS is projecting that the overall impact of changes finalized in this rule will result in a -1 percent change in payments to neurology as a specialty broadly. The expiration of temporary pandemic-related relief measures at year end has forced CMS to finalize a reduction in the fee schedule conversion factor of nearly 4.5 percent. The AAN is committed to payment reform efforts to promote a sustainable payment system and to working with regulators and legislators to ensure that CMS appropriately values the work done by neurologists. Working with Congress to avert the impending cuts before the end of the year will continue to be a top priority for the AAN. **The AAN strongly urges you to tell your representatives to take action before the end of the year to prevent impending cuts.**

Evaluation and Management Visits

CMS is continuing its ongoing review of the evaluation and management (E/M) code descriptors and guidelines, with the next phase of revisions scheduled for implementation on January 1, 2023. Impacted E/M code sets include inpatient/observation care, consultations, emergency department, nursing facility, home and residence, and prolonged services. As with the first phase of revisions, which included outpatient E/M services, CMS will be aligning its coding and documentation policies with changes laid out by the CPT Editorial Panel for the facility-based services, except when coding for prolonged inpatient services. In the proposed rule, CMS stated its disagreement with the time threshold at which prolonged service code 99418 should be reported. The CPT Editorial Panel finalized 99418 for 2023 to capture prolonged total time on the date of an inpatient EM service. CMS has instead finalized code G0316 and will not cover 99418. While the AAN is highly supportive of the broader updates, the AAN is concerned that the addition of the G-code will lead to confusion among practitioners and prove to be disruptive when medical specialty societies educate members about the correct coding for prolonged services.

In a significant win for AAN advocacy, CMS has finalized a delay of policies impacting split (or shared) E/M visits that were set to go into effect on January 1, 2023, until January 1, 2024, to allow for further dialogue with stakeholders. The AAN has been leading efforts to modify policies finalized in the 2022 Physician Fee Schedule that would detrimentally impact team-based care. The AAN is pleased to see that CMS is delaying implementation

of these policies to allow for additional stakeholder feedback. The AAN has previously submitted recommendations to the agency regarding how existing policies could be modified to promote team-based care. The American Medical Association has referred this issue to a work group of members from the CPT Editorial Panel and the Relative Value Scale Update Committee (RUC) which is soliciting feedback from participating societies. The AAN continues to be engaged in this process and will provide comments as solutions are proposed.

Global Surgical Packages

In the proposed rule, the agency solicited comments regarding strategies for improving global surgical package valuations. The AAN has long held concerns related to inappropriate valuations of these packages and the subsequent fiscal redistributions stemming from budget neutrality requirements. The AAN has particular concerns relating to the number and level of pre-operative and post-operative E/M visits in the packages. In response to the solicitation for comments, the AAN submitted feedback urging the agency to continue its critical work in this area and offered a robust set of recommendations regarding the best path forward. CMS noted in response to commenters that there is no consensus on a strategy for revaluing the global packages and the agency will consider the strategies proposed by commenters as they explore next steps. We remain highly encouraged by CMS seeking comment in preparation for future rulemaking to address potentially inflated values.

Telehealth Regulations

The AAN is pleased that CMS is implementing provisions of the Consolidated Appropriations Act of 2022 that extend certain flexibilities in place during the COVID-19 Public Health Emergency (PHE) for 151 days after the PHE ends, including allowing telehealth services to be furnished in any geographic area and at any originating site, including the beneficiary's home, and allowing certain services to be furnished via audio-only telecommunications systems.

CMS finalized policy so that the agency will not be adding the Telephone E/M codes to the Medicare Telehealth list. As such, telephone E/M services will remain covered through the expiration of the 151-day period following the end of the PHE, at which point they will revert to bundled status.

Consistent with the AAN's advocacy, CMS is finalizing a number of policies intended to promote access to telehealth services, including making several services that are temporarily available as telehealth services for the duration of the PHE available through CY 2023 on a Category 3 basis. This will allow more time for collection of data that could support their eventual inclusion as permanent additions to the Medicare telehealth services list. CMS finalized its proposal to add CPT codes 95970, 95983, and 95984, which describe general brain nerve neurostimulation, to the Medicare Telehealth Services List on a Category 3 basis. CMS also finalized its proposal to add CPT codes 97151–97158, 0362T, and 0373T on a Category 3 basis, which include emotional/behavior assessment, psychological, or neuropsychological Testing and Evaluation services.

The agency also finalized a proposal that allows providers to bill for telehealth services with the place of service indicator that would have been used if the service had been furnished in-person. Claims will require the modifier "95" to identify them as services furnished as telehealth services. Claims can continue to be billed with the place

of service code that would be used if the telehealth service had been furnished in-person through the latter of the end of 2023 or end of the year in which the COVID-19 PHE ends.

EEG National Coverage Determination Changes

The AAN is pleased with the decision by CMS to finalize a proposal to remove the national coverage determination (NCD) for ambulatory EEG monitoring and allow coverage to be determined by local Medicare contractors. Since the implementation of the revised code set in 2020, the NCD no longer reflects the practice of medicine or current standards of care.

Valuation of Specific Codes

As part of the periodic CPT code review process, ultrasound codes 76881, 76882, and new code for neuromuscular ultrasound, 76883, were reviewed by the AMA RUC for 2023. In the proposed rule, CMS did not accept the recommendations of the RUC, and stated their intent to finalize values that would be a decrease to the code set. During the comment period, the AAN stated its disagreement with the agency's rationale to reduce the values for these services. In a win for the AAN, stakeholder feedback compelled CMS to reverse their proposal and finalize the rates recommended by the RUC, which translates to a work RVU increase for these services.

Quality Payment Program

As in previous years, the rule includes proposed policy updates impacting the Quality Payment Program (QPP), which includes the Merit-based Incentive Payment System (MIPS), Advanced Alternative Payment Model (APM), and MIPS Value Pathways (MVPs).

As required by statute for the 2023 performance year, the weights for MIPS performance categories are: 30 percent for Quality, 30 percent for Cost, 15 percent for Improvement Activities, and 25 percent for Promoting Interoperability. The category weights have not changed in comparison to last year. CMS will maintain the 75-point performance threshold for performance year 2023. CMS notes that performance year 2022 was the final year for MIPS adjustments for exceptional performance.

To better account for improvements made within the Cost category, CMS has established a maximum cost improvement score of one percentage point out of 100 percentage points available for the Cost performance category starting with the 2022 performance period. Within the Improvement Activities component, CMS has added four activities: two in the Achieving Health Equity category (IA_AHE_10 and IA_AHE_11), one geared towards Expanding Practice Access (IA_EPA_6), and the last for Emergency Response Preparedness relating to the COVID-19 pandemic (IA_ERP_6). Within the Promoting Interoperability category, query of prescription drug monitoring program (PDMP) will now be a required measure worth 10 points. In the Quality performance category, CMS is amending benchmarking policy and clarifying policy relating to topped out measures.

The rule makes permanent the eight-percent minimum Generally Applicable Nominal Risk Standard for Advanced APMs that was set to expire in 2024.

MIPS Value Pathway

The rule finalizes five new MIPS Value Pathways (MVPs), two of which focus on neurologic conditions to be made available beginning with the 2023 performance year. By adding these five MVPs to the seven finalized last year, providers will have access to 12 MVPs starting in 2023, three of which are available to neurologists:

- "Optimal Care for Patients with Episodic Neurological Conditions MVP" focuses on the clinical theme of promoting quality care for patients suffering from episodic neurologic conditions.
- "Supportive Care for Neurodegenerative Conditions MVP" focuses on the clinical theme of promoting quality care for patients with cognitive-based neurologic disorders such as dementia, Parkinson's disease, and amyotrophic lateral sclerosis.
- "Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes MVP," which was finalized last year, focuses on the clinical theme of providing fundamental prevention and treatment of those patients at risk for, or that have had, a stroke. This rule makes a minor change to what was previously finalized, with the addition of an ONC Direct Review attestation requirement for this MVP.

The AAN actively engaged with CMS during the development process for these MVPs and provided the agency with feedback throughout. The AAN will continue to provide feedback to the agency in refining these models in our comments.

CMS has committed that, for future MVP development and adjustments, it will post a draft version of each candidate MVP on the Quality Payment Program website (https://qpp.cms.gov) and will communicate the opportunity to provide public feedback on the candidate MVP through QPP standard channels, including QPP listserv messaging. This is consistent with the AAN's request for a more transparent and stakeholder-focused MVP development process.

Access AAN resources to help you understand MVPs and explore the new Stroke MVP. The AAN will provide resources for the new episodic and neurodegenerative MVPs here.