CY 2023 Medicare Physician Fee Schedule (MPFS) Final Rule Summary

November 4, 2022

On November 1, 2022, the Centers for Medicare and Medicaid Services (CMS) issued the final rule for the Medicare Physician Fee Schedule (MPFS) for CY 2023.

The CY 2023 final rule is 3,304 pages in length and located in its entirety at the following link: https://www.cms.gov/files/document/cy2023-physician-fee-schedule-final-rule-cms-1770f.pdf.

The following is intended to serve as a summary of the final changes.

Highlights

- The CY 2023 conversion factor (CF) is finalized to be $33.0607, a decrease of 4.5 percent from CY 2022 CF of $34.6062. Changes to relative value units (RVUs) for physician work, practice expense, and malpractice will impact reimbursement, again negatively for many which are highly specialized. Note that in addition to the conversion factor reduction, physician reimbursement is also currently scheduled to be subjected to an additional -4% for PAYGO and -2% for sequestration. It is anticipated that Congress will address these cuts in some fashion; however, the timing and extent of action is unknown at this time.
- Changes in evaluation and management (E/M) visits once again have an impact and those specialties that predominantly provide E/M with little practice expense (PE) values will see increases in the value of these codes. Other changes in values due to misvaluation, year two phase-in of values for clinical labor, continued phase-in of equipment and supply pricing, and changes in malpractice premium data for CY 2023 will negatively impact specialties like radiology, interventional radiology, vascular surgery, and nuclear medicine.
- CMS provided a breakdown of the estimated impacts to specialties to identify where they will be setting wise, non-facility vs. facility. These impacts only reflect the estimated RVUs and do not reflect the impact per the CF. The overall percentages are based on aggregate estimated allowed charges summed across services by all providers for a specialty and compared to the previous year. The value impact may not be the same at the single practitioner level for a given specialty.

TABLE 148: CY 2023 PFS Estimated Impact on Total Allowed Charges by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Interventional Pain Management	$929	-1%	-1%	0%	-2%
Interventional Radiology	$467	-1%	-3%	0%	-3%
Radiology	$4,734	-1%	-1%	0%	-2%
Vascular Surgery	$1,104	0%	-3%	0%	-3%

* Column F may not equal the sum of columns C, D, and E due to rounding.

CMS also provided additional estimated impact on total charges by setting after requests to provide more transparency.

TABLE 149: CY 2023 PFS Estimated Impact on Total Allowed Charges by Setting

(A) Specialty	(B) Total Non-Facility/Facility	(C) Allowed Charges (mil)	(D) Combined Impact
Interventional Pain Management	*TOTAL*	$929	-2%
	Non-facility	$732	-2%
	Facility	$196	0%
Interventional Radiology	*TOTAL*	$467	-3%
	Non-facility	$367	-4%
	Facility	$100	-1%
Radiology	*TOTAL*	$4,734	-2%
	Non-facility	$4,503	-2%
	Facility	$230	-1%
Vascular Surgery	*TOTAL*	$1,104	-3%
	Non-facility	$816	-4%
	Facility	$287	-2%

- After reviewing and accepting new wage and survey data, CMS has updated the prices for several clinical staff types relevant to radiology. The Vascular Interventional Technologist (L041A—formerly Angio Technician) increased from 0.60 to 0.84, the Mammography Technologist (L043A) increased from 0.63 to 0.79, and the CT 2 Technologist increased from 0.76 to 0.78. CMS will continue to consider public comment related to wage updates for clinical staff during the remainder of the 4-year phase-in.
- Based on the changes to the CF and RVUs the impact at the code level for IR services ranges from slight increases overall to decreases that average 6 percent for non-facility (office-based) settings and an average decrease of 4 percent for the physician in a facility (hospital-based and ambulatory surgical center) settings.
- CMS indicated, as required for CY 2023, the work floor geographic practice cost index (GPCI) is set at 1.000 and reflected in the final values. GPCIs reflect the cost-of-living differences between geographical locations and must be reviewed and if necessary, adjusted every 3 years.
- CMS updates to Malpractice (MP) RVUs
    - The last update was in 2020 and is required every 3 years. It was also finalized in 2020 to align the MP RVUs and MP GPCI at same time to increase efficiency.
    - Updated MP premium data was obtained from all 50 State insurance rate filings.
    - CMS finalized plans to improve and obtain a more comprehensive data set to identify specific insurer names when they do not match CMS database or include specialties not tracked by CMS and to create true risk index calculation.
- CMS included several codes and code sets for CY 2023 valuation; not all RUC recommendations were accepted.
    - Percutaneous Arteriovenous Fistula Creation (CPT® codes 36836 and 36837) – **New for 2023**
    - Arthrodesis Decompression (CPT® codes 22630, 22632, 22633, 22634, 63052, and 63053)
    - Percutaneous Nephrolithotomy (CPT® codes 50080, 50081)
    - 3D Rendering with Interpretation and Report (CPT® code 76377)

- CMS intends to accept and move forward with the AMA CPT® Editorial Panel changes to the rest of the evaluation and management (E/M) visits (inpatient and observation visits, emergency department (ED) visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment) except critical care services to match the framework of the outpatient and office E/M visits which changed in 2021.
- CMS addressed telehealth after the public health emergency (PHE) ends. As of this summary, the PHE is scheduled to end in January 2023.
- CMS finalized codes, that are not part of the telehealth list of services identified as continuing permanently or temporarily as a Category 3 telehealth service, which will end on day 152 post the end of the PHE (e.g., initial inpatient CPT® codes 99221, 99222, and 99223).
- CMS has also finalized that the telephone or audio-only codes (99441-99443) will not be available on the list of telehealth services after the end of the PHE.
- CMS finalized a proposal for services included on the list of telehealth services performed on or before the 151st day after the PHE ends will continue to be paid at the same rate as if performed in person with modifier 95 applied to the telehealth services.
- CMS addressed Split (or Shared) Visits for new and established patients will be fully integrated in policy year beginning 2024, a one-year delay, to allow full acquaintance and implementation of the other E/M visit changes for providers.
- CMS continues to seek comments on the following as they move forward into future rulemaking:
    - Adjusting RVUs To Match PE Share of the Medicare Economic Index (MEI)
    - Standardize and make routine the valuation for indirect practice expense (PE)
    - Strategies for Improving Global Surgical Package Valuation

Within the following pages are expanded details and explanations of the key highlights pertinent to interventional radiology as outlined above.

Payment Rates

The Protecting Medicare and American Farmers from Sequester Cuts Act signed into law December 10, 2021, after the CY 2022 final rule, increased the CF for 2022 by 3 percent. This increase was only valid for 2022 and means the CF for 2023 was already set to decrease. Because this was a Congressional update, CMS is limited to address or override the 3 percent decrease which must be applied to the CY 2022 CF when determining the value for CY 2023. In addition, CMS had proposed to apply a decrease of 1.5 percent for budget neutrality but finalized a 1.6 percent decrease as the budget neutrality adjustment. This results in an overall 4.5 percent decrease to the CF and does not account for any relative value unit (RVU) changes for 2023. The CY 2023 conversion factor (CF) is finalized to be $33.0607, a decrease of 4.5 percent from CY 2022 CF of $34.6062. Table 146 in the final rule shows the method for calculating the conversion factor.

TABLE 146: Calculation of the CY 2023 PFS Conversion Factor

CY 2022 Conversion Factor		34.6062
Conversion Factor without CY 2022 Protecting Medicare and American Farmers from Sequester Cuts Act		33.5983
Statutory Update Factor	0.00 percent (1.0000)	
CY 2023 RVU Budget Neutrality Adjustment	-1.60 percent (0.9840)	
CY 2023 Conversion Factor		**33.0607**

The lowering of the CF does result in decreases for many specialties and their estimated impacts and CMS also applied additional decreases to relative value units (RVUs) due to misvalued codes and year two phase-in of clinical labor updates.

Once again specialties which rely on Evaluation and Management (E/M) services, or clinical labor, to make up the bulk of their practice expense will see positive impacts related to RVU changes. Other specialties such as radiology, interventional radiology, vascular surgery, and nuclear medicine will see negative impacts related to RVU changes. This is primarily due to how practice expense contributes to the valuation of services. For specialties like interventional radiology, the cost of equipment and supplies to perform procedures make up the bulk of valuation and clinical labor and E/M are much smaller factors.

CMS must maintain budget neutrality when increasing or decreasing payment rates. CMS cannot exceed their projected budget each year by $20 million above or below the set amount. CMS will instead "pay" for the increase in values to codes and overall reimbursement for specialties by lowering the rates or values of codes primary to other specialties which provides them with the added monies needed to make up the difference.

The changes in RVUs alone are expected to negatively impact several specialties. The impacts outlined in the following table do not account for or incorporate the decrease in the conversion factor. CMS clarified how the percent changes impact each society, "*The percentage changes in Table 148 are based upon aggregate estimated PFS allowed charges summed across all services furnished by physicians, practitioners, and suppliers within a specialty to arrive at the total allowed charges for the specialty, and compared to the same summed total from the previous calendar year. Therefore, they are averages, and may not necessarily be representative of what is happening to the particular services furnished by a single practitioner within any given specialty.*"

In addition to the estimated impact on total allowed charges by specialty provided in Table 148, CMS also provided additional estimated impact on total charges by setting (Table 149) after requests by stakeholders in response to CY 2022 rulings to provide more transparency.

TABLE 148: CY 2023 PFS Estimated Impact on Total Allowed Charges by Specialty

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	Non-facility	$816	-4%
	Facility	$287	-2%

Based on the finalized changes to the RVUs for CY 2023, the impact at the code level for interventional radiology (IR) services tracks with the breakdown from CMS in Table 149. The additional impact of the CF does reflect a slight increase to some IR services, larger increases to E/M codes, but mostly decreases that average 6 percent in non-facility (office-based) settings and decreases that average 4 percent for the physician in facility (hospital-based and ambulatory surgical center) settings.

Practice Expense RVUs – Clinical Labor

CMS updated the values for clinical labor for the first time in 20 years in CY 2022 using CY 2019 survey data from the Bureau of Labor and Statistics (BLS) and other supplementary data when there is no BLS data available. Due to budget neutrality, which is applied to clinical labor changes, specialties like family practice which have a higher-than-average share of the direct costs continue to see increases in values of codes while for other specialties like interventional radiology, which have labor that is a lower-than-average share of the direct costs, continue to see decreases in code value. This is due to the equipment and supplies which are high valued for interventional radiology and the lower impact clinical labor values have on the same services.

CY 2023 begins year two of four years of clinical labor updates. CMS has stated from the beginning if there is new data available, it can be presented to CMS at any time during the 4-year phase-in for consideration. Based on SIR feedback, CMS has updated the prices for several clinical staff types relevant to radiology. The Vascular Interventional Technologist (L041A—formerly Angio Technician) increased from 0.60 to 0.84, the Mammography Technologist (L043A) increased from 0.63 to 0.79, and the CT 2 Technologist increased from 0.76 to 0.78. CMS will continue to consider public comment related to wage updates for clinical staff during the remainder of the 4-year phase-in.

TABLE 8: CY 2023 Clinical Labor Pricing Update

Labor Code	Labor Description	Source	CY 2021 Rate Per Minute	Final Rate Per Minute	Y2 Phase-In Rate Per Minute	Total % Change
L041A*	**Vascular Interventional Technologist**	ASRT Wage Data	0.41	**0.84**	0.624	**104%**
L041B	Radiologic Technologist	BLS 29-2034	0.41	0.63	0.520	54%
L041C	Second Radiologic Technologist for Vertebroplasty	BLS 29-2034	0.41	0.63	0.520	54%
L043A*	Mammography Technologist	ASRT Wage Data	0.43	**0.79**	0.611	**84%**
L046A	CT Technologist*	ASRT Wage Data	0.46	**0.78**	0.622	**70%**
L047A	MRI Technologist	BLS 29-2035	0.47	0.76	0.615	62%
L054A	Vascular Technologist	BLS 19-1040	0.54	0.91	0.735	69%

* Updated for CY 2023

Malpractice RVUs

CMS finalized updates to Malpractice (MP) RVUs, last updated in CY 2020 and required every three years. Additionally, as previously finalized, CMS will align updates to the MP RVUs and MP Geographic Practice Cost Index (GPCI) at the same time to increase efficiency.

To update MP RVUs and GPCIs, premium data is obtained from State insurance rate filings. CMS was able to obtain data from all 50 states. CMS finalized plans to improve and obtain a more comprehensive data set to identify specific insurer names when they do not match the CMS database or include specialties not tracked by CMS to create true risk index calculation.

CMS also finalized a correction to the ratesetting calculation error identified in the proposed MP RVUs for technical component (TC) only services. The technical error mapped all TC-only services to a 1.00 risk value which resulted in a TC and professional component (26) MP RVU distribution error. Due to the lack of professional liability premium data for CY 2022, a risk factor of 1.00 was assigned to TC-only services. However, CMS'

expanded data collection efforts produced sufficient premium data allowing the ability to directly assign a risk value for TC-only services for CY 2023. Due to a technical error, a 1.0 risk factor continued to be assigned resulting in incorrect calculations which CMS will rectify by mapping TC-only services to allergy/immunology which carries a risk index value of 0.430.

CMS has also finalized, for those specialties where the updated MP premium data results in 30 percent or greater reduction in risk index compared to 2022, the phase-in of these impacted MP RVUs at 1/3 of the change each year over next three years, until the next update, rather than over two years. The following table outlines the projected risk index for selected specialties over the next three years. None of the societies selected are impacted by the more than 30 percent change and are not expected to have values as part of the phase-in.

CY 2023 Malpractice Risk Index and Premium Amounts by Specialty

Specialty Code	Specialty Name	2022 Service Risk Group	2022 Risk Index*	2022 Normalized Premium Rate	2023 Service Risk Group	2023 Risk Index**	2024 Risk Index**	2025 Risk Index**	2025 Normalized Premium Rate
09	Interventional Pain Management	All	1.240	$26,587	All	1.202	1.202	1.202	$26,013
30	Diagnostic Radiology	All	0.937	$20,105	All	1.011	1.011	1.011	$21,889
77	Vascular Surgery	All	2.812	$60,318	All	2.830	2.830	2.830	$61,259
94	Interventional Radiology	All	1.144	$24,532	All	1.407	1.407	1.407	$30,457

*Note: CMS is moving from a "Risk Factor" construct to a "MP Risk Index" beginning in 2023. 2022 Risk Index is shown above for illustrative purposes only. See "CY 2023 Medicare PFS Update to the GPCIs and MP RVUs, Interim Report" for more information.
**Note: This reflects the policy of allowing up to 3 years for risk index values to fully reflect the updated premium data as discussed in "CY 2023 Medicare PFS Update to the GPCIs and MP RVUs, Interim Report."
Specifically, each specialty's risk index value may not decrease by more than 33% of the specialty's CY2022 risk index value in a given year.

Geographic Practice Cost Index (GPCI)

Geographic practice cost index (GPCI) reflects the cost-of-living differences between geographical locations and must be reviewed and if necessary, adjusted every 3 years. CMS completed their review of GPCIs and as required for CY 2023 the work floor GPCI is set at 1.000 and reflected in the finalized values. Alaska continues the permanent 1.500 work GPCI and the Frontier States continue the permanent 1.000 floor for work RVUs as well.

CMS finalized changes to the following California identities:

- Los Angeles-Long Beach-Anaheim MSA, containing Orange County and Los Angeles County, by one unique locality number, 18, as opposed to two, retiring locality number 26, as it is no longer needed.
- San Francisco-Oakland-Berkeley MSA containing San Francisco, San Mateo, Alameda, and Contra Costa counties by one unique locality number, 05, as opposed to four, retiring locality numbers 06 and 07, as they are no longer needed.
- Modify the MSA names as follows:
  - San Francisco Oakland-Berkeley (San Francisco Cnty) locality (locality 05) would become San Francisco-Oakland-Berkeley (San Francisco/San Mateo/Alameda/Contra Costa Cnty)
  - Los Angeles-Long Beach-Anaheim (Los Angeles Cnty) locality (locality 18) would become Los Angeles-Long Beach-Anaheim (Los Angeles/Orange Cnty).
  - Because Marin County is in a transition area and subject to the hold harmless provision CMS must retain a unique locality number for San Francisco-Oakland-Berkeley (Marin Cnty), locality 52.

Due to timing constraints relating to the operationalization of the finalized locality changes, implementation will

begin in CY 2024. Since the finalized changes have no payment implications under PFS, the CY 2023 data reflected in Addenda D and E within the final rules do not reflect the California locality changes as finalized; there will be no changes to the existing locality numbers 05, 06, 08, or 26 for CY 2023. The changes will be reflected in Addenda D and E for CY 2024 when the finalized changes are operationalized.

Specific Codes and Code Set Valuations

Percutaneous Arteriovenous Fistula Creation (CPT® codes 36836 and 36837)

In October 2021 the CPT® Editorial Panel created CPT® codes 36836 *(Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (e.g., transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation)* and 36837 *(Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (e.g., transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation)* to describe the creation of an arteriovenous fistula in an upper extremity via a percutaneous approach.

CPT® codes 36836 and 36837 replace the HCPCS G codes G2170 and G2171 which CMS confirmed in the final rule.

The RUC recommended a work RVU of 7.50 for CPT® code 36836, and a work RVU of 9.60 for CPT® code 36837. CMS indicated they disagree with the RUC-recommended RVUs for CPT® codes 36837 and 36837 and felt they were too high when compared to other codes with similar time values. Per CMS, The RUC-recommended RVU of 7.50 for 36836 is the second highest RVU for codes with 55 to 65 minutes of intraservice time and 94 to 114 minutes of total time, with RVUs ranging from 2.45 to 8.84. Similarly, the RUC-recommended RVU of 9.60 for 36837 is the third highest RVU for codes with 65 to 85 minutes of intraservice time and 109 to 129 minutes of total time, with RVUs ranging from 4.69 to 10.95. Therefore, CMS finalized a work RVU of 7.20 for CPT® code 36836 using the second reference code of 36905 due to the intraservice and total time were closer in value.

CMS did state they also disagreed with the RUC-recommended work RVU of 9.60 for CPT® code 36837. They agreed the relative difference in work between CPT® codes 36836 and 36836 is equivalent to the RUC-recommended interval of 2.10 RVUs and believed the use of an incremental difference between these CPT® codes is a valid methodology for setting values, especially in valuing services within a family of codes where it is important to maintain an appropriate intra-family relativity. Therefore, CMS finalized a work RVU of 9.30 for CPT® code 36837, based on the RUC-recommended interval of 2.10 RVUs and using the CMS proposed work RVU of 7.20 for CPT® code 36836.

Regarding direct practice expense (PE), CMS sought additional information on two equipment and four supply items presented for CPT® code 36836 and 36837. Specifically, CMS sought comments on the following:

- Justification for two of the four supply items and their inclusion as direct PE inputs. Specifically, the RUC submitted invoices for two new equipment inputs; one for a Wavelinq EndoAVF generator (EQ403) used for CPT® code 36837, and the other for an Ellipsys EndoAVF generator (EQ404) used for CPT® code 36836.
- Comments and requesting information why the Wavelinq generator (EQ403) are so much more expensive at $18,850 as compared with the Ellipsys generator (EQ404) at $3,000.
- In addition, supply items SD149 (catheter, balloon inflation device) and SD152 (catheter, balloon, PTA) as direct PE inputs for CPT® codes 36836 and 36837.
- Comments and requesting information if supply items SD149 and SD152 are typical, and how often they are used, for CPT® codes 36836 and 36837.
- Supply items SF056 (detachable coil) and SF057 (non-detachable embolization coil) included as direct PE

inputs for CPT® code 36837 (one each for SF056 and two each for SF057).

- Comments and requesting information with a justification for keeping supply items SF056 and SF057 as direct PE inputs for CPT® code 36837.
- Request to know if both supply items are typical and how often they are used for CPT® code 36837. If these supply inputs are not typical for these procedures, CMS believes they should be removed from the direct PE inputs.

After consideration of the public comments, CMS finalized the work RVU values for the Percutaneous Arteriovenous Fistula Creation code family (CPT codes 36836 and 36837) as proposed at 7.20 and 9.30 respectively. They also finalized the direct PE inputs for CPT codes 36836 and 36837 without refinement. HCPCS codes G2170 and G2171 were deleted as proposed.

Arthrodesis Decompression (CPT® codes 22630, 22632, 22633, 22634, 63052, and 63053)

The codes 63052 *(Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg,spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment (List separately in addition to code for primary procedure))* and 63053 *(Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg,spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment (List separately in addition to code for primary procedure))* were new add-on codes available in 2022 to report decompression when performed in conjunction with posterior interbody arthrodesis at the same interspace.

CMS finalized the current work RVU for CPT® code 63052 despite a surveyed change in time. In the CY 2022 MPFS final rule, CMS finalized a work RVU of 4.25 for CPT® code 63052 for CY 2022 based on a crosswalk to CPT® code 22853. Survey data showed a 5-minute intraservice time increase for CPT® code 63052, CMS continues to believe the crosswalk to CPT® code 22853 is still valid, given only 3 months has passed between the two surveys, and it has the same intraservice time as CPT® code 63052, is a spinal procedure, and is an add-on code to the same base codes as CPT® code 63052.

CPT® code 63053 has a finalized work RVU or 3.19 based on the intraservice time ratio between CPT® codes 63052 and 63053 ((30 minutes/40 minutes) * 4.25 = 3.19). CMS believes the intraservice time ratio between the two CPT® codes is still valid, given that only 3 months passed between the two surveys. They have finalized a work RVU of 3.78 based on the surveyed time changes for CPT® codes 63052 and 63053 ((40 minutes/45 minutes) * 4.25 = 3.78) to maintain consistency with previous analysis of time and intensity of these two add-on codes. CMS indicated there was no obvious or explicitly stated rationale in the RUC's April recommendations for the change in intensity between the January 2021 and April 2021 surveys, so CMS utilized the changes in surveyed time to calculate the final work RVUs for CPT® codes 63052 and 63053.

Percutaneous Nephrolithotomy (CPT® codes 50080, 50081)

In September 2021, the CPT® Editorial Panel revised the descriptors to CPT® codes *50080 (Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (e.g., stone[s] up to 2 cm in a single location of kidney or renal pelvis, nonbranching stones))* and 50081 *(Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (e.g., stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)).*

Recent claims data identified a site of service anomaly screen, as they are performed less than 50 percent of the time in the inpatient setting, both codes have 90-day global periods, which include post-op inpatient hospital E/M

services in their value, typical of major surgery codes. The revised code descriptors also include image guidance and nephrostomy tube placement, which were not present in the old descriptors, and were reported as procedures separately from CPT® codes 50081 and 50082.

Codes 50081 and 50082 have not been reviewed for nearly 30 years and the recommended intra-service times dropped by 76.9 percent from the current intra-service time and the RUC recommended work RVU is reduced only by 85.9 percent. CMS does not agree with the RUC recommended work RVU and originally proposed a work RVU of 12.11 for CPT® code 50080 with the RUC recommended 90 minutes of intra-service time and 244 minutes of total time. CMS also proposed a work RVU of 20.61 for CPT® code 50081, based on the proposed CPT® code 50080's work RVU of 12.11 plus the RUC-recommended incremental difference 8.50 work RVUs between CPT® code 50080 and CPT® code 50081 (12.11 + 8.50 = 20.61).

After review and consideration of all comments on its proposals for CPT® codes 50080 and 50081, CMS believes that the value of code 76000 is not entirely accounted for in its original proposed valuations and are adding fluoroscopy's 0.30 work RVUs to both CPT® codes 50080 and 50081, since this work was omitted from its proposed valuations. CMS finalized 12.41 work RVUs (12.11 + 0.30) for CPT® code 50080 and 20.91 work RVUs (12.11 + 8.50 + 0.30) for CPT code 50081 for CY 2023. CMS also finalized the direct PE inputs as proposed and as recommended by the RUC for both of these codes.

3D Rendering with Interpretation and Report (CPT® code 76377)

CMS finalized the RUC recommended direct PE inputs without refinement and the work RVU of 0.79 for CPT® code 76377. CMS continues to believe and reiterated that CPT® code 76376 and 76377 would be more appropriately viewed as belonging to the same code family and requested they be surveyed together.

Table 16 reflects the current, RUC recommendations and CMS finalized work RVUs for selected codes. Table 20 reflects the new invoices received by CMS and are specific to the new Endo AVF codes.

TABLE 16: CY 2023 Work RVUs for New, Revised, and Potentially Misvalued Codes

HCPCS	Descriptor	Current work RVU	RUC work RVU	CMS work RVU	CMS time refinement
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	22.09	22.09	22.09	No
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace	5.22	5.22	5.22	No
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	27.75	26.80	26.80	No
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment	8.16	7.96	7.96	No

36836	Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	NEW	7.50	7.20	No
36837	Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (eg, transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation	NEW	9.60	9.30	No
50080	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; simple (eg, stone[s] up to 2 cm in single location of kidney or renal pelvis, nonbranching stones)	15.74	13.50	12.41	No
50081	Percutaneous nephrolithotomy or pyelolithotomy, lithotripsy, stone extraction, antegrade ureteroscopy, antegrade stent placement and nephrostomy tube placement, when performed, including imaging guidance; complex (eg, stone[s] > 2 cm, branching stones, stones in multiple locations, ureter stones, complicated anatomy)	23.50	22.00	20.91	No
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment	4.25	5.70	4.25	No
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment	3.19	5.00	3.78	No
76377	3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation	0.79	0.79	0.79	No

TABLE 20: CY 2023 New Invoices

CPT/HCPCS codes	Item Name	CMS code	Average price	No. of invoices	NF Allowed Services
36836	Ellipsys Vascular Access Catheter	SD351	$6,000.00	1	91
36836	Ellipsys EndoAVF generator	EQ404	$3,000.00	1	91
36837	Wavelinq EndoAVF catheters	SD350	$7,000.00	1	73
36837	Wavelinq EndoAVF generator	EQ403	$18,580.00	1	73

Addressing Changes to "Other" Evaluation and Management (E/M) Services

CMS finalized its intention to accept and move forward with the AMA CPT® Editorial Panel changes to what they are calling "Other E/M" visits (inpatient and observation visits, emergency department (ED) visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment) except critical care services to match the framework (medical decision making or time-based) of the outpatient and office E/M visits which changed in 2021.

The AMA released an early update of the Other E/M visit code changes in July 2022 which go into effect January 1, 2023. The full pdf of changes can be found at https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf.

Throughout the MPFS final rule for CY 2023, CMS reiterated the coding and definition changes and deletions included in the AMA transmittal. The only area where CMS indicated they were not in agreement centered around the application of prolonged services codes. This matches the disagreement between the two entities for the outpatient and office E/M visits as well.

CMS did finalize revised definitions for "initial" and "subsequent" in relation to E/M visits for inpatient services. CMS does not recognize subspecialties, as is outlined in the CPT® manual, so CMS finalized the following language.

> *An initial service would be defined as one that occurs when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty who belongs to the same group practice during the stay.*
>
> *A subsequent service would be defined as one that occurs when the patient has received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty who belongs to the same group practice during the stay.*

CMS is moving forward with the revisions as updated by the AMA for CPT® codes 99221 through 99223 and 99231 through 99236. CMS finalized when using the time-based method for E/M visits, the code level increment of time must be "met or exceeded" as it is listed in the code descriptor.

CMS also finalized retaining the policy that a billing practitioner can only bill for one hospital inpatient or observation care code for an initial visit, a subsequent visit, or inpatient or observation care (including admission and discharge), as appropriate, once per calendar date.

Prolonged Services

CMS finalized three new HCPCS codes to be used in place of the AMA created CPT® code 99418 for prolonged services. One code for hospital inpatient or observation care (G0316), one for nursing facilities (G0317), and one for home or residence (G0318). The prolonged services codes are not billable in conjunction with emergency department (ED) visit codes because ED visits are not reported based on time spent with the patient. The code for use for prolonged services of inpatient time-based visits in 2023 to be used with Medicare beneficiaries is:

- **G0316** (*Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 on the same date*

of service as other prolonged services for evaluation and management 99358, 99359, 99418). (Do not report G0316 for any time unit less than 15 minutes)).

The new HCPCS codes by CMS will replace the existing codes for inpatient prolonged services CPT® codes 99356 (*Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation Evaluation and Management service)*) and 99357 (*Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)*).

As with the outpatient prolonged services, CMS did not agree with the AMA how time was counted to meet the threshold for billing the new codes. In addition, the prolonged service code G0316 can only be used with the highest-level hospital inpatient or observation care visit codes (CPT® codes 99223, 99233, and 99236) when the time-based method is used.

CMS finalized the prolonged service period described by G0316 begins 15 minutes after the total times (as established in the Physician Time File) for CPT® codes 99223, 99233, and 99236 have been met. Additionally, CMS finalized G0316 prolonged code would be for a 15-minute increment, and the entire 15-minute increment must be completed in order to bill G0316.

CMS also finalized their proposal that G0316 would apply to both face-to-face and non-face-to-face time spent on the patient's care within the survey timeframe. For CPT® codes 99223 and 99233, this would be time spent on the date of encounter. For CPT® code 99236, this would be time spent within 3 calendar days of the encounter.

CMS provided a table which reviews the application of the new HCPCS prolonged service visit codes.

TABLE 24: Required Time Thresholds to Report Other E/M Prolonged Services

Primary E/M Service Prolonged	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	G0316	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	G0316	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	G0316	125 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	n/a	n/a	n/a
Emergency Department Visits	n/a	n/a	n/a
Initial NF Visit (99306)	G0317	95 minutes	1 day before visit + date of visit +3 days after
Subsequent NF Visit (99310)	G0317	85 minutes	1 day before visit + date of visit +3 days after
NF Discharge Day Management	n/a	n/a	n/a
Home/Residence Visit New Pt (99345)	G0318	141 minutes	3 days before visit + date of visit +7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	112 minutes	3 days before visit + date of visit +7 days after
Cognitive Assessment and Care Planning	n/a	n/a	n/a
Consults	n/a	n/a	n/a

* Time must be used to select visit level. Prolonged service time could be reported when furnished on any date within the primary visit's surveyed timeframe, and would include time with or without direct patient contact by the physician or NPP. Consistent with CPT's approach, we would not assign a frequency limitation.

Split (or Shared) Visits

CMS finalized Split (or Shared) Visits for new and established patients which will be fully integrated in policy year beginning 2024, a one-year delay, to allow full acquaintance and implementation of the other E/M visit changes for providers.

E/M Visit Code Family	2022 & 2023 Definition of Substantive Portion	2024 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/Nursing Facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

Acronyms: E/M (Evaluation and Management), MDM (medical decision-making).
*Office visits will not be billable as split (or shared) services.

After the Public Health Emergency (PHE)

As of the release of the CY 2023 MPFS final rule, the Health and Human Services (HHS) Secretary had extended the public health emergency (PHE) through January 13, 2023. Many of the provisions and waivers as part of the initial response to the COVID-19 pandemic will continue through the end of the PHE and as finalized in separate legislation for 151 days post the end of the PHE.

CMS finalized making several services, currently temporarily available as telehealth services during the PHE, available through CY 2023 on a Category III basis, allowing more time for CMS to evaluate whether these services could eventually be included permanently on the Medicare telehealth services list.

Codes not part of the telehealth list of services identified as continuing permanently or temporarily as a Category 3 telehealth service will end on day 152 post the end of the PHE (e.g., initial inpatient CPT® codes 99221, 99222, and 99223). Telehealth visits will no longer be allowed for patients in their homes or anywhere outside of an originating site other than the statutory exceptions for diagnosis, evaluation and treatment of mental health disorders, home dialysis end stage renal disease related visits, and diagnosis, evaluation, and treatment of acute stroke symptoms.

CMS finalized the telephone or audio-only codes (99441-99443) will not be available on the list of telehealth services after the end of the PHE. Since they are audio-only and will not meet the criteria which will require all telehealth services to be performed by real-time audio-video capabilities after the end of the PHE and 151-day extension.

CMS finalized codes included on the list of telehealth services performed on or before the 151st day after the PHE ends will continue to be paid at the same rate as if performed in person with modifier 95 applied to the telehealth services. For telehealth services on day 152 and beyond they will no longer require modifier 95, but the appropriate place of service (POS) code (02 or 10) must be applied to process for payment.

Under Medicare Part B, certain types of services, including diagnostic tests, services incident to physicians' or practitioners' professional services, and other services, CMS requires to be furnished under specific minimum levels of supervision by a physician or practitioner. For professional services furnished incident to the services of the billing physician or practitioner and many diagnostic tests, direct supervision is required.

CMS again reiterated that "…outside the circumstances of the PHE, direct supervision requires the immediate availability of the supervising physician or other practitioner, but the professional need not be present in the same room during the service." CMS has clarified "immediate availability" requirement means in-person, physical, not virtual, availability in two different recent rulemakings (April 6, 2020 IFC (85 FR 19245) and the CY 2022 PFS final rule (86 FR 65062)).

CMS also reminded stakeholders that after December 31st of the year in which the PHE ends, the pre-PHE rules for direct supervision would apply. CMS is not proposing to make the temporary exception to allow immediate availability for direct supervision through virtual presence permanent; instead, they are continuing to seek comments whether to allow flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology.

CMS is also seeking comment on the possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time, audio/video technology for only a subset of services. CMS recognizes for some services there are potential concerns over patient safety if physician supervision was provided without physical presence by the physician. As discussed in last year's final rule, and based on gaps in the currently available evidence, CMS needs more information as they review whether to make permanent a temporary exception to their direct supervision policy.

Future Considerations and Request for Comments by CMS

A focus of the CY 2023 proposed and final rule cycle by CMS was to begin the conversation regarding the need for ongoing updates and utilization of data used to set values and payment rates for CPT®/HCPCS codes. As outlined previously in this summary and other publications in recent years, CMS has been using data which is not current or due to other factors has not been updated when setting rates. This leads to comments from stakeholders arguing proposed values are inaccurate or invalid because the data used is so old. This is creating significant issues for CMS and stakeholders. As part of the CY 2023 MPFS final rule, CMS has initiated the conversation regarding adjusting RVUs to match the PE of the Medicare Economic Index (MEI), indirect practice expense (PE), and improved global surgical package valuation. Rather than moving forward with any proposed changes these updates would provide for CY 2023, CMS is seeking stakeholder comment on moving forward with best practice in updating and timing of implementation of new data.

Medicare Economic Index (MEI)

The Medicare Economic Index (MEI) relates to the reasonable charge-based payment methodology in place for physicians' services prior to MPFS. For services after June 30, 1973, the charge levels could not exceed the level from previous year except when the Secretary determines on the basis of appropriate economic index data, a higher level is justified by year-to-year economic changes. CMS began calculating the MEI on July 1, 1975, and continues to do so today for several statutory and other purposes. The MEI reflects the weighted-average annual price change for various inputs involved in furnishing physicians' services.

The MEI is a fixed-weight input price index comprised of two broad categories: (1) Physicians' own time (compensation); and (2) physicians' practice expense (PE). The current 2006-based MEI is based on data collected by the AMA for self-employed physicians from the Physician Practice Information Survey (PPIS). The AMA has not conducted another survey since the 2006 data collection effort. Due to this the MEI continues to be based on 2006-based costs.

In a report from August 2012, recommendations were made to CMS on updating the MEI in the future. Recommendations included that CMS should research whether using self-employed physician data for the MEI cost weights continues to be the most appropriate approach given the trend toward larger, physician-owned practices, as well as movement from physician-owned practices toward hospital-owned practices. In addition, it was recommended CMS scan for and research additional data sources that may allow for more frequent updates to the MEI's cost categories and their respective weights.

Previous updates to the conversion factor were calculated based on a statutory formula that used a combination of the sustainable growth rate (SGR) and the MEI. The legislation contained within MACRA in April 2015

repealed this for CYs 2015 and beyond and the MEI was no longer used in calculating the yearly CF. However, it continues to be used when calculating other factors.

Historically the MEI was also used to calculate the GPCI cost share weights to weigh the four components of practice expense GPCI (employee compensation, office rent, purchased services, and medical equipment, supplies, and other miscellaneous expenses). The MEI was last updated in 2014 and CMS believes they need to update it to reflect more current market conditions impacting physicians for physician services. CMS is delaying the implementation of proposed rebased and revised MEI cost weights for both MPFS ratesetting and CY 2023 GPCIs. This will allow stakeholders to provide feedback on the proposed cost share weights.

CMS proposed and finalized to rebase and revise the MEI based on a methodology using publicly available data sources for input costs representing all types of physician practice ownership, not just self-employed physicians. CMS explained in great detail within the CY 2023 MPFS ruling how they plan to calculate the MEI to allow interested parties and stakeholders to provide input on the process for updating and applying the calculated MEI for future ratesetting. It is recommended to review section II.M of the CY 2023 MPFS proposed rule for the details and methodology provided by CMS.

Although CMS agrees that the MEI cost weights need to be updated to reflect more current market conditions faced by physicians in providing services and has finalized the proposal to rebase and revise the MEI, CMS is finalizing to delay the implementation of the rebasing and revising MEI cost weights for both rate setting and finalized GPCIs. By delaying, CMS believes it will give interested parties the time to review and comment on the revised MEI cost share weights as well as their potential impacts prior to implementation. The CY 2023 MEI update is 3.8 percent, which is based on the latest available historical data through the 2nd quarter of 2022.

Indirect Practice Expense

CMS is looking to standardize and make routine the valuation for indirect practice expense (PE) and seeking comments from stakeholders on how best to do this. Direct PE RVUs is made up of clinical labor, equipment, and supplies. Per CMS, Indirect PE RVUs is made up of costs such as office rent, IT costs, and other non-clinical expenses. It has been over a decade since this information was last updated and the primary source of the information is the Physician Practice Information Survey (PPIS), by the AMA.

The last survey was conducted in 2007 and 2008 and reflects 2006 data. The participants were self-employed physicians and selected nonphysician practitioners. CMS has received concerns regarding how indirect PE is allocated and the data was surveyed. Concerns expressed included lack of ways to update data based on experience, payment differentials for same procedure depending on setting, and may not accurately reflect variation in practice expense across different types of services, different practice processes, or changing business models.

Another concern raised to CMS which can impact interventional radiology, is the high cost of supplies and equipment, including disposable supplies, which are not relevant to allocating indirect PE. Similarly, the work RVUs for surgical procedures in the facility setting are not relevant for allocating indirect PE, but it is agreed work in the office setting may be relevant to allocating indirect PE. CMS did indicate they have not seen any data or have not been presented with any to support shifting the indirect PE allocation based on setting or specialty which would improve the allocations of indirect PE to reflect true costs. CMS also fears if indirect PE were allocated based on setting or specialty it might create unintended scenarios where access to care could be limited, or a reduction in competition and lack of small group practices or individual clinicians who provide some services in facility settings.

The following are the points which CMS is looking for stakeholder feedback related to indirect practice expense.

1. Appropriate instrument, methods, and timing for updating specialty-specific PE data:

   a. Potential approaches to design, revision, and fielding of a PE survey that foster transparency (for example, transparency in terms of the methods of survey design, the content of the survey instrument, and access to raw results for informing PFS ratesetting); and
   b. Mechanisms to ensure that data collection and response sampling adequately represent physicians and non-physician practitioners across various practice ownership types, specialties, geographies, and affiliations.
2. Alternatives to the above that would result in more predictable results, increased efficiencies, or reduced burdens. For example:
   a. Use of statistical clustering or other methods that would facilitate a shift away from specialty-specific inputs to inputs that relate to homogenous groups of specialties without a large change in valuation relative to the current PE allocations.
   b. Avenues by which indirect PE can be moved for facility to non-facility payments, based on data reflecting site of service cost differences.
   c. Methods to adjust PE to avoid the unintended effects of undervaluing cognitive services due to low indirect PE.
   d. A standardized mechanism and publicly available means to track and submit structured data and supporting documentation that informs pricing of supplies or equipment.
   e. Sound methodological approaches to offset circularity distortions, where variable costs are higher than necessary costs for practices with higher revenue.
3. Comments on the cadence, frequency, and phase-in of adjustments for each major area of prices associated with direct PE inputs (Clinical Labor, Supplies/Equipment).
   a. Whether CMS should stagger updates year-to-year for each update or establish "milestone" years at regular intervals during which all direct PE inputs would be updated in the same year.
   b. The optimal method of phasing in the aggregate effect of adjustments, such that the impacts of updates gradually ramp up to a full 100 percent over the course of a few years (for example, 25 percent of the aggregate adjustment in Year 1, then 50 percent of the aggregate adjustment in Year 2, etc.).
   c. How often CMS should repeat the cycle to ensure that direct PE inputs are based on the most up-to-date information, considering the burden of data collection on both respondents and researchers fielding instruments or maintaining datasets that generate data.
4. Comments on evolving trends in healthcare business arrangement, use of technology, or similar topics which might impact indirect PE calculations.
5. Comments whether any PE data inputs may be obsolete, unnecessary, or misrepresentative of actual costs in operating a medical practice.
6. Comments regarding any information which CMS may not have considered or discussed about updating and maintaining PE data inputs.
   a. Including unintended negative or positive outcomes which would result from the changes to overall strategy.
   b. Specifically focused on the following, concerns about beneficiaries' access to care, possible consolidation of group practices, or burden on small group or solo practitioners.
   c. Public comments on any collateral program integrity or quality issues that could arise from potential updates.
   d. Feedback to ensure the response includes discussion of any possible health equity impacts.

In response to CMS' request for information (RFI), most commenters recommended that CMS delay any change to update the indirect PE survey inputs. And in fact, many urged CMS to wait for the AMA data collection efforts prior to implementing changes. In its response to the RFI, the AMA RUC emphasized the fact that CMS has used AMA physician cost data for 50 years in updating the MEI and 30 years updating RBRVUs, and recommended CMS

continue to work with the AMA and wait for an updated data set to become available for use.

In this final rule, CMS has expressed that the AMA PPIS continues to be the best source of information currently available. That being said, CMS understands concerns by those interested parties asking for policy that better reflects ever-changing health care costs may be addressed by consistent and transparent data updates. In addition, those comments that focused on current survey data alone were incongruent with those comments about updating the PE methodology that took into account automation advancements and associated software costs. As CMS stated, *"…there are a number of competing concerns that CMS must take into account when considering updated data sources, which also should support and enable ongoing refinements to our PE methodology."*

Overall, CMS has stated the methodology used to establish the PE RVUs and "*identify refinements*" will continue. As part of this effort, CMS has contracted with the RAND Corporation to develop and assess improvements in the current methodology used to distribute indirect practice costs in determining PE RVUs; provide alternative methodologies for determining PE RVUs; and look at alternative data sources which could be used to update indirect practice cost estimates. For CY 2023, there are no specific proposals.

Strategies for Improving Global Surgical Package Valuation

Another area where CMS is seeking comments is related to the valuation of global surgical packages for 0-, 10-, and 90-day global periods. Specifically comments on how to improve the accuracy of payment for global surgical packages. According to CMS there are over 4,000 physicians' services paid as global packages under MPFS. Global packages generally include the surgical procedure and any services typically provided during the pre- and postoperative periods (including evaluation and management (E/M) services and hospital discharge services).

This is not the first time CMS has sought comments on the global surgical packages but are now seeking comments related to the multi-year data which has been collected and impact of other payment policies for services which may have an impact.

Previous data and a report by RAND concluded the number of E/M visits occurring post-surgery were significantly less than calculated into the value of the surgical service. There was significant pushback to this in previous comment periods, but no data was provided to CMS to support the findings by RAND were incorrect and the number of E/M visits were more frequent than collected.

CMS is requesting comments on whether changes to health care delivery, including changes in coordination of care and use of medical technology over the past 3 decades, as well as during the recent PHE, have impacted: The number and level of postoperative E/M visits needed to provide effective follow-up care to patients; the timing of when postoperative care is being provided; and who is providing the follow-up care. CMS believes some beneficiaries are not receiving the number of calculated post-surgical E/M visits, some are not receiving any due to lack of need or comprehensive discharge planning, and some follow-up E/M visits are being scheduled outside the global period or physicians are instructing patients to follow-up with another physician without formally transferring care.

CMS is also asking for comments on the following:

- Whether, or how, recent changes in the coding and valuation of separately billable E/M services may have impacted global packages.
- Whether global packages, and especially those with 10- and 90-day global periods, continue to serve a purpose when physicians could otherwise bill separately not only for the postoperative E/M visits they furnish, but also for aspects of postoperative care management they furnish for some patients. CMS wants to know what, if any, components of preoperative or postoperative care are currently only compensated as part of payment for global packages.

- Whether there is any perceived misalignment between E/M visit included in global packages and separately billable E/M services.
- Whether alternatives such as requesting the RUC to make recommendations on new values, or another method proposed by the public would be more suitable.

Because the volume of services which include a global surgical period, CMS is considering various approaches for any updates, which include the following:

- Revaluing all 10- and 90-day global packages at one time (perhaps with staggered implementation dates);
- Revaluing only the 10-day global packages (because these appear to have the lowest rate of postoperative visit performance, per RAND's analysis of claims data);
- Revaluing 10-day global packages and some 90-day global packages (such as those with demonstrated low postoperative visit performance rates as identified in RAND's analysis of these services); or
- Relying on the Potentially Misvalued Code process to identify and revalue misvalued global packages over the course of many years.

Regarding the RFI for overall relevance of global packages, several commenters stated that although patients in general seem in greater need of critical care, there is also increasing pressure on practitioners to discharge patients from hospitals and arrange at-home care postoperatively. Some commenters stated that in-person postoperative visits with the surgeon are the standard of care and should continue to be so. There were commenters that stated there may be clinical reasons why a patient would not require in-person postoperative care within the global period; while others suggested there may clinical reasons why a patient would receive postoperative care from a practitioner rather than the surgeon. Based on these comments, CMS believes the feedback received demonstrates there may be variations in patients' individual postoperative care needs.

There were a variety of payment comments received ranging from Medicare paying for postoperative care as standalone visits; postoperative care should be reimbursed separately at a higher rate; global packages are necessary because they reduce administrative burden of practitioners and ensure payment of NPPs and clinical staff. Comments were also received regarding the valuation of E/M visits embedded in global packages as compared to standalone E/M visits; specifically, the value of global packages should be increased to reflect the increase in standalone visits.

There were comments received regarding global package valuation: some indicated agreement that global surgical packages are misvalued and encouraged CMS to revalue the packages in order to reduce the impacts of improper valuation on the relative value scale. Some provided agreement that packages were misvalued, but suggested CMS continue to work with impacted parties to find a method for revaluation. Others stated that they do not believe that global packages were misvalued; or, if they are misvalued, they should be revalued on a clinical and case-by-case basis using the RUC process or the Potentially Misvalued Code process. A few suggested that CMS and the RUC collaborate on a specific method to revalue global packages.

CMS received diverse comments on approaches for revaluing the codes, including revaluing all 10-and 90-day packages, revaluing some 10-and 90-day packages, or focusing just on the 10-day packages.

As evidenced by the diversity of comments provided, CMS acknowledges there is not a clear consensus on this issue or the appropriate strategy for valuing global surgical periods. However, CMS also continues to believe (1) there is strong evidence suggesting that the current RVUs for global packages are inaccurate; (2) many interested parties agree that the current values for global packages should be reconsidered, whether they believe the values are too low or too high; and (3) it is necessary to take action to improve the valuation of the services currently valued and paid under the PFS as global surgical packages.

In this year's comment solicitation, CMS received a diversity of perspectives on: whether the global packages are misvalued; if misvalued, whether they are undervalued or overvalued; whether CMS should continue to value

them through our current processes or develop a new methodology that better addresses the challenges created by bundled payments; and whether global packages should be revalued individually or in their entirety. As evidenced by the totality of the comments and discussion from prior years, there are a few common views that can be identified:

- The issue of global valuation is complex, as there are a large number of codes involved and their valuation impacts the PFS RV scale;
- Valuing the work and other inputs of the global packages accurately is critical to ensure practitioners providing those services are paid appropriately as well as no unfair impact on practitioners paid outside of 10- and 90-day global packages;
- The variety of procedures paid under global packages may mean all-inclusive approaches to valuation may not achieve the level of accuracy expected; and
- Good data analysis is vital to use as a strong foundation for any method of valuing these packages.

MIPS Value Pathways (MVPs)

In the final rule, CMS further refined the implementation of MIPS Value Pathways (MVPs). CMS finalized five new MVPs as well as revisions to the seven previously established MVPs. Modifications include a means for providing feedback on new and established MVPs on the QPP website. CMS has also updated rules regarding MVP maintenance and participation options, as well as several additions and revisions to subgroup reporting such as eligibility, registration and scoring.

The five new MVPs are:

- Advancing Cancer Care;
- Optimal Care for Kidney Health;
- Optimal Care for Neurological Conditions;
- Supportive Care for Cognitive-Based Neurological Conditions; and
- Promoting Wellness

The category weights for the 2023 performance year will remain the same as 2022: Quality – 30%, Cost – 30%, PI – 25%, and IAs – 15%. These percentages will likely remain fixed for the future of the MIPS program. As finalized in the 2022 final rule, CMS will not offer an exceptional performance adjustment beginning in 2023.

CMS has finalized removal of the following measures:

- #76: Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections
- #110: Preventive Care and Screening: Influenza Immunization
- #111: Pneumococcal Vaccination Status for Older Adults 5

Measures #110 and #111 were combined into a new measure, #493: Adult Immunization Status, which includes immunization for influenza, tetanus and diphtheria, zoster and pneumococcal in its numerator.

CMS also finalized adding the following new measure to the Diagnostic Radiology measure set:

- #487: Screening for Social Drivers of Health

Requiring Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs Payable Under Medicare Part B to Provide Refunds with Respect to Discarded Amounts

Section 90004 of the Infrastructure Investment and Jobs Act (Pub. L. 117-9, November 15, 2021) amended section 1847A of the Act to require manufacturers to provide a refund to CMS for certain discarded amounts from a refundable single-dose container or single-use package drug. The refund amount is either as noted in section 1847A(b)(1)(B) of the Act, in the case of a single source drug or biological, or as noted in section 1847A(b)(1)(C) of the Act in the case of a biosimilar biological product, multiplied by the amount of discarded drug that exceeds an applicable percentage, which is required to be at least 10 percent, of total charges (subject to certain exclusions) for the drug in a given calendar quarter.

The JW modifier policy has been in place since 2017, and CMS is codifying it without change in this final rule. Providers should currently be reporting the JW modifier on their claims, as well as documenting the discarded amounts in the beneficiary's medical records. CMS understands that providers do not currently have the capability to accept or report the JZ modifier. They expect that a 6-month delay in the requirement to use the JZ modifier would allow providers sufficient time to incorporate necessary updates to their claims systems to report JZ data. If a provider cannot report the JW or JZ modifiers as required by October 1, 2023, they should hold their claims until they are able to do so. Claims submitted without required modifier data will not be accepted.

CMS is finalizing implementation of this provision including: a definition of which drugs are subject to refunds (and exclusions), an applicable percentage for certain drugs reconstituted in hydrogel, how discarded amounts of drugs are determined, a refund calculation methodology, a dispute resolution process, and enforcement provisions. However, CMS is not finalizing that the initial reports will be sent no later than October 1, 2023. Although they are finalizing the proposed timeline for sending reports to manufacturers, the effective date of the provision remains January 1, 2023, as required by statute, and reports will be sent for calendar quarters beginning on or after this date.

For the final rule, CMS reanalyzed JW modifier data from 2020 as if the data represented dates of service on or after the effective date of section 90004 of the Infrastructure Act (that is, January 1, 2023). CMS found one billing and payment code had a change in status from single source to multiple sources. Therefore, CMS updated the analysis to reflect this change under the provisions finalized as proposed in section II.A. of the proposed rule and as provided in the final rule. Based on CMS data, there would be approximately $74.7 million in refunds due from manufacturers for the calendar year of 2020 ($18.68 million each calendar quarter).

Table 150 - Estimated Refund Amounts Based on CY 2020 JW Modifier Data

HCPCS Code	CY 2020 Total Allowed Amount	Percent Units Discarded	Percent Discarded Units – 10%	Estimated Annual Refund	Estimated Quarterly Refund
J9043	$135,486,070.48	28.14%	18.14%	$24,577,173.19	$6,144,293.30
J0223	$3,953,268.84	20.80%	10.80%	$426,953.03	$106,738.26
Q4195	$6,233,097.24	20.47%	10.47%	$652,605.28	$163,151.32
J0775	$55,922,761.61	20.18%	10.18%	$5,692,937.13	$1,423,234.28
J9262	$342,668.12	19.96%	9.96%	$34,129.74	$8,532.44
J0565	$2,724,776.12	19.55%	9.55%	$260,216.12	$65,054.03
J2796	$240,489,959.82	16.83%	6.83%	$16,425,464.26	$4,106,366.06
J9309	$49,591,437.88	15.79%	5.79%	$2,871,344.25	$717,836.06
Q4106	$2,098,353.95	15.07%	5.07%	$106,386.55	$26,596.64
J1640	$7,204,322.44	14.87%	4.87%	$350,850.50	$87,712.63

J9153	$8,651,250.34	14.63%	4.63%	$400,552.89	$100,138.22
J9179	$45,528,228.20	12.60%	2.60%	$1,183,733.93	$295,933.48
J9264	$352,102,440.73	14.46%	4.46%	$15,703,768.86	$3,925,942.21
J2562	$17,986,116.53	12.41%	2.41%	$433,465.41	$108,366.35
Q4101	$2,701,473.78	12.11%	2.11%	$57,001.10	$14,250.27
J9229	$25,178,218.24	12.06%	2.06%	$518,671.30	$129,667.82
J3300	$8,454,347.46	11.44%	1.44%	$121,742.60	$30,435.65
J0485	$65,351,086.26	11.43%	1.43%	$934,520.53	$233,630.13
J9042	$167,324,055.19	11.41%	1.41%	$2,359,269.18	$589,817.29
J2997	$71,164,289.22	11.34%	1.34%	$953,601.48	$238,400.37
J9352	$9,562,087.18	10.95%	0.95%	$90,839.83	$22,709.96
J0291	$264,734.03	10.80%	0.80%	$2,117.87	$529.47
J9205	$54,328,144.16	10.50%	0.50%	$271,640.72	$67,910.18
J9307	$22,242,951.07	10.27%	0.27%	$60,055.97	$15,013.99
J9228	$375,059,594.99	10.06%	0.06%	$225,035.76	$56,258.94
Total				$74,714,077.48	$18,678,519.35

There are several limitations to this analysis that could substantially affect the total quarterly refund. Since new drugs are continually being approved, this estimate does not consider newer drugs that will meet the definition of refundable single-dose container or single-use package drug on or after the effective date of January 1, 2023.

CMS also noted that this estimate is based on CY 2020 data for discarded drug amounts, which they believe to be an underestimate due to the frequent omission of the JW modifier. Once CMS begins to edit claims for both the JW and JZ modifiers, reported discarded drug amounts will likely increase. Other substantial changes to this estimate may occur if a billing and payment code no longer meets this definition. For example, if a generic version of one of these drugs is marketed, the billing and payment code will become a multiple source drug code and will no longer meet the definition of refundable single-dose container or single-use package drug. Subsequently, the manufacturers will not be responsible for refunds under this provision. There may be changes in the percent discarded units for a given refundable single-dose container or single-use package drug if the manufacturer introduces additional vial sizes or modifies the vial size to reduce the amount discarded. Lastly, since data from the CMS website only includes billing and payment codes on the ASP drug pricing file and implementation of section 90004 of the Infrastructure Act is not restricted to billing and payment codes included on the file, there may be other applicable data that was not assessed as part of this estimate.

Submitting Comments

Comments to CMS regarding the MPFS final rule must refer to file code **CMS-1770-F** and be received no later than **5 pm EST January 1, 2023**. Electronic submission is encouraged by CMS, http://www.regulations.gov. Follow the instructions under the "submit a comment" tab.