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

Each year, the Centers for Medicare & Medicaid Services (CMS) proposes regulations that impact the reimbursement of physicians. On July 7, 2022, CMS issued a proposed rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule in 2023. The proposed rule illustrates the importance of the AAN's regulatory advocacy efforts on behalf of neurologists and their patients. Due to budget neutrality requirements, CMS is projecting that the overall impact of changes contained in the proposed rule will result in a one-percent reduction in payments to neurology as a specialty broadly. Due to the expiration of temporary relief measures at year end, CMS is currently predicting a reduction in the Fee Schedule conversion factor of nearly 4.5 percent. The AAN will continue to work with legislators to avert impending cuts. 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.

Evaluation and Management Visits

CMS continues its ongoing review of the evaluation and management (E/M) code descriptors and guidelines, with the next phase of revisions scheduled for 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 inpatient services. The AAN remains highly supportive of the new coding and payment structure.

In a significant win for AAN advocacy, CMS is proposing to delay 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 recently submitted recommendations to the agency regarding how existing policies could be modified to promote team-based care and will continue to work with coalition partners in support of a permanent change.

Global Surgical Packages

The agency is soliciting 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. The AAN has urged the agency

on several occasions to continue its critical work in this area and is encouraged by CMS seeking comment in preparation for future rulemaking to address potentially inflated values.

Telehealth Regulations

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 in any originating site setting, including the beneficiary's home, and allowing certain services to be furnished via audio-only telecommunications systems.

CMS is proposing 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, which will allow more time for collection of data that could support their eventual inclusion as permanent additions to the Medicare telehealth services list. CMS is proposing 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, while soliciting comment on concerns regarding patient safety and whether these services are appropriate for inclusion on the Medicare Telehealth Services List outside the circumstances of the PHE. CMS is also proposing 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, while soliciting comments on patient safety concerns. CMS is declining to add Telephone E/M services on a Category 3 basis, citing statutory constraints.

The agency proposes 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.

EEG National Coverage Determination Changes

Following the implementation of the revised code set for long-term EEG monitoring services in 2020, the AAN, in collaboration with the American Clinical Neurophysiology Society and the National Association of Epilepsy Centers, requested that CMS remove a national coverage determination (NCD) for ambulatory EEG monitoring. The societies assert the NCD, effective June 1984, no longer reflects the practice of medicine and coverage should be determined by local Medicare contractors. The AAN is pleased CMS is seeking feedback on this proposal and will reassert our support for removing the NCD during the comment period.

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 as follows: 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 is also proposing to 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 proposes to establish 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 is proposing to add four activities: two in the Achieving Health Equity category, one geared towards Expanding Practice Access, and the last for Emergency Response Preparedness relating to the COVID-19 pandemic. Within the Promoting Interoperability category, the rule proposes to change the query of prescription drug monitoring program (PDMP) from a voluntary to 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 proposes to make 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 proposes 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, CMS is proposing that providers will have access to twelve MVPs starting in 2023, three of which are available to neurologists:

- *Newly Proposed:* “Optimal Care for Patients with Episodic Neurological Conditions MVP” focuses on the clinical theme of promoting quality care for patients suffering from episodic neurological conditions.
- *Newly Proposed:* “Supportive Care for Neurodegenerative Conditions MVP” focuses on the clinical theme of promoting quality care for patients with cognitive-based neurological 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 proposes 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.

Access AAN resources to help you understand MVPs and explore the new Stroke MVP.