



## 2023 Medicare Physician Fee Schedule Final Rule

For the entire final rule: [Calendar Year \(CY\) 2023 Medicare Physician Fee Schedule Final Rule | CMS](#)

### ✓ **CY 2023 PFS Ratesetting and Conversion Factor**

The final CY 2023 PFS conversion factor is \$33.06, a decrease of \$1.55 to the CY 2022 PFS conversion factor of \$34.61.

### ✓ **Updated Medicare Economic Index (MEI) for CY 2023**

The final CY 2023 MEI update is 3.8 percent based on the most recent historical data available. The rebased and revised MEI weights were not used in CY 2023 PFS ratesetting.

### ✓ **Evaluation and Management (E/M) Visits**

As part of the ongoing updates to E/M visit codes and related coding guidelines that are intended to reduce administrative burden, the AMA CPT Editorial Panel approved revised coding and updated guidelines for Other E/M visits, effective January 1, 2023. This is similar to the approach CMS finalized in the CY 2021 PFS final rule for office/outpatient E/M visit coding and documentation. CMS finalized and adopted most of these AMA CPT changes in coding and documentation for Other E/M visits (which include hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment) effective January 1, 2023. This revised coding and documentation framework includes CPT code definition changes (revisions to the Other E/M code descriptors), including:

- New descriptor times (where relevant).
- Revised interpretive guidelines for levels of medical decision making.
- Choice of medical decision making or time to select code level (except for a few families like emergency department visits and cognitive impairment assessment, which are not timed services).
- Eliminated use of history and exam to determine code level (instead there would be a requirement for a medically appropriate history and exam).

CMS finalized the proposal to maintain the current billing policies that apply to the E/Ms while we consider potential revisions that might be necessary in future rulemaking.

CMS also finalized creation of Medicare-specific coding for payment of Other E/M prolonged services, similar to what CMS adopted in CY 2021 for payment of Office/Outpatient prolonged services. These services will be reported with three separate Medicare-specific G codes.

CPT 99356-99357 have been deleted by the AMA from the CPT 2023 code set effective January 1, 2023. The CPT Editorial Panel created new codes to replace these codes; however for Medicare purposes we will not use those CPT codes but instead will use G0316

Reference: [MM12982 - Medicare Physician Fee Schedule Final Rule Summary: CY 2023 \(cms.gov\)](#)



- G0316 for reporting prolonged hospital inpatient or observation services
- G0317 for prolonged nursing facility services
- G0318 for prolonged home or residence services

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

Primary E/M Service	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	140 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	G0318	110 minutes	3 days before visit + date of visit + 7 days after
Cognitive Assessment and Care Planning (99483)	G2212	100 minutes	3 days before visit + date of visit + 7 days after
Consults	n/a	n/a	n/a

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

✓ Split (or Shared) E/M Visits

For CY 2023, we finalized a year-long delay of the split (or shared) visits policy we established in rulemaking for 2022. This policy determines which professional should bill for a shared visit by defining the “substantive portion,” of the service as more than half of the total time. Therefore, for CY 2023, as in CY 2022, the substantive portion of a visit is comprised of any of the following elements:

- History.
- Performing a physical exam.
- Medical Decision Making.
- Spending time (more than half of the total time spent by the practitioner who bills the visit).

As finalized, clinicians who furnish split (or shared) visits will continue to have a choice of history, or physical exam, or medical decision making, or more than half of the total practitioner time spent to define the “substantive portion” instead of using total time to determine the substantive portion, until CY 2024.

**Critical Care**

CMS issued a technical correction clarifying that the reporting threshold time for the add-on code for critical care services is the same for split (or shared) critical care as for critical care that isn’t split (or shared). Use CPT Code 99292 to report additional, complete 30-minute time increments



provided to the same patient, therefore it isn't reported until at least 104 minutes are spent (74 + 30 = 104 minutes).

## ✓ Telehealth Services

For CY 2023, CMS is adding new HCPCS codes to the list of Medicare telehealth services on a Category 1 basis, specifically HCPCS codes G0316, G0317, G0318, G3002, and G3003. CMS is also keeping many services that are temporarily available as telehealth services for the duration of the COVID-19 Public Health Emergency (PHE) on a Category 3 basis through CY 2023.

This will allow additional time for the collection of data that may support their inclusion as permanent additions to the Medicare Telehealth Services List. CMS finalized our proposal to extend the duration of time that services are temporarily included on the telehealth services list during the PHE for at least a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act, 2022 (CAA, 2022).

We finalized the proposal to allow physicians and practitioners to continue to bill with the place of service (POS) indicator that would have been reported had the service been furnished in-person. These 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 later of the end of CY 2023 or end of the year in which the PHE ends.

The Telehealth Originating Site Facility Fee has been updated for CY 2023, which can be found with the list of Medicare Telehealth List of Services at the following website:

<https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes>

### Telehealth Origination Site Facility Fee Payment Amount Update

The payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge, or \$28.64 for CY 2023 services. We base this on the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the Social Security Act. The 2023 MEI increase is 3.8%. The patient is responsible for any unmet deductible amount and Medicare coinsurance

## ✓ Behavioral Health Services

### Behavioral Health Services

In light of the current needs among Medicare beneficiaries for improved access to behavioral health services, CMS has considered regulatory revisions that may help to reduce existing barriers and make greater use of the services of behavioral health professionals, such as licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs). Therefore, CMS is finalizing the proposal to add an exception to the direct supervision requirement under our "incident to" regulation at 42 CFR 410.26 to allow behavioral health services to be provided under the general supervision of a physician or non-physician practitioner (NPP), rather than under direct supervision, when these services or supplies are furnished by auxiliary personnel, such as LPCs and LMFTs, incident to the services of a physician (or NPP). CMS is also clarifying that any



service furnished primarily for the diagnosis and treatment of a mental health or substance use disorder can be furnished by auxiliary personnel under the general supervision of a physician or NPP who is authorized to furnish and bill for services provided incident to their own professional services. CMS believes that this change will facilitate access and extend the reach of behavioral health services. Finally, CMS indicated in the final rule that we intend to address payment for new codes that describe caregiver behavioral management training in CY 2024 rulemaking.

In the 2022 CMS Behavioral Health Strategy (<https://www.cms.gov/cms-behavioral-health-strategy>), CMS included a goal to improve access to, and quality of, mental health care services and included an objective to “increase detection, effective management, and/or recovery of mental health conditions through coordination and integration between primary and specialty care providers.” In CY 2017 and 2018 PFS rulemaking, CMS received comments that initiating visit services for behavioral health integration (BHI) should include in-depth psychological evaluations delivered by a clinical psychologist (CP), and that CMS should consider allowing professionals who were not eligible to report the approved initiating visit codes to Medicare to serve as a primary hub for BHI services. Considering the increased needs for mental health services and feedback we have received, we are finalizing our proposal to create a new General BHI code describing a service personally performed by CPs or clinical social workers (CSWs) to account for monthly care integration where the mental health services furnished by a CP or CSW are serving as the focal point of care integration. CMS is also finalizing the proposal to allow a psychiatric diagnostic evaluation to serve as the initiating visit for the new general BHI service.

### ✓ **Chronic Pain Management Services**

CMS finalized new HCPCS codes, G3002 and G3003, and valuation for chronic pain management and treatment services (CPM) for CY 2023. We believe the CPM HCPCS codes will improve payment accuracy for these services, prompt more practitioners to welcome Medicare beneficiaries with chronic pain into their practices, and encourage practitioners already treating Medicare beneficiaries who have chronic pain to spend the time to help them manage their condition within a trusting, supportive, and ongoing care partnership.

The finalized codes include a bundle of services furnished during a month that we believe to be the starting point for holistic chronic pain care, aligned with similar bundled services in Medicare, such as those furnished to people with suspected dementia or substance use disorders. We have finalized the CPM codes to include the following elements in the code descriptor: diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and coordination between relevant practitioners furnishing care, such as physical and occupational therapy, complementary and integrative care approaches, and community-based care, as appropriate.

Codes for valuation for chronic pain management and treatment services (CPM)

HCPCS G3002 and G3003

Goals:

Improve accuracy of payment



Prompt more practitioners to welcome beneficiaries with chronic pain into their practice  
Encourage practitioners with current patients with chronic pain to spend time to help manage their condition

### ✓ Opioid Treatment Programs (OTPs)

To stabilize methadone pricing for CY 2023 and subsequent years, we're finalizing our proposal to revise our method for pricing the drug component of the methadone weekly bundle and the add-on code for take-home supplies of methadone. As proposed, we'll base the payment amount for the drug component of HCPCS codes G2067 and G2078 for CY 2023 and subsequent years on the payment amount for methadone in CY 2021 and update this amount annually to account for inflation using the Producer Price Index for Pharmaceuticals for Human Use (Prescription).

### ✓ Audiology Services

CMS finalized a policy to allow beneficiaries direct access to an audiologist without an order from a physician or NPP for non-acute hearing conditions. The finalized policy will use a new modifier – instead of using a new HCPCS G-code as we proposed – because we were persuaded by the commenters that a modifier would allow for better accuracy of reporting and reduce burden for audiologist. The service(s) can be billed using the codes audiologists already use with the new modifier, and include only those personally furnished by the audiologist. The finalized direct access policy will allow beneficiaries to receive care for non-acute hearing assessments that are unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids. This modification in our finalized policy necessitates multiple changes to our claims processing systems, which will take some time to fully operationalize, but audiologists may use modifier AB, along with the finalized list of 36 CPT codes, for dates of service on and after January 1, 2023.

CMS finalized the proposal to permit audiologists to bill for this direct access (without a physician or practitioner order) once every 12 months per beneficiary. Medically reasonable and necessary tests ordered by a physician or other practitioner and personally provided by audiologists will not be affected by the direct access policy, including the modifier and frequency limitation.

### ✓ Dental and Oral Health Services

Effective for CY 2023, CMS:

1) finalized our proposal to clarify and codify certain aspects of the current Medicare FFS payment policies for dental services when that service is an integral part of specific treatment of a beneficiary's primary medical condition, and

2) other clinical scenarios under which Medicare Part A and Part B payment can be made for dental services, such as dental exams and necessary treatments prior to, or contemporaneously with, organ transplants, cardiac valve replacements, and valvuloplasty procedures.

We are also finalizing payment for dental exams and necessary treatments prior to the treatment for head and neck cancers starting in CY 2024, and finalizing a process in CY 2023 to review and



consider public recommendations for Medicare payment for dental service in other potentially analogous clinical scenarios.

Finally, we are working to address commenters' thoughtful feedback and questions regarding the operational aspects of billing and claims processing for these services.

### ✓ **Skin Substitutes**

CMS proposed several changes to the policies for skin substitute products to streamline the coding, billing, and payment rules and to establish consistency with these products across the various settings. Specifically, CMS proposed to change the terminology of skin substitutes to 'wound care management products', and to treat and pay for these products as incident to supplies under the PFS beginning on January 1, 2024. After reviewing comments on the proposals, we understand that it would be beneficial to provide interested parties more opportunity to comment on the specific details of changes in coding and payment mechanisms prior to finalizing a specific date when the transition to more appropriate and consistent payment and coding for these products will be completed. We plan to conduct a Town Hall in early CY 2023 with interested parties to address commenters' concerns as well as discuss potential approaches to the methodology for payment of skin substitute products under the PFS. We will take into account the comments we received in response to CY 2023 rulemaking and feedback received in association with the Town Hall in order to strengthen proposed policies for skin substitutes in future rulemaking.

### ✓ **Colorectal Cancer Screening**

For CY 2023, we are finalizing, as proposed, two updates to expand our Medicare coverage policies for colorectal cancer screening in order to align with recent United States Preventive Services Task Force and professional society recommendations.

First, we are expanding Medicare coverage for certain colorectal cancer screening tests by reducing the minimum age payment and coverage limitation from 50 to 45 years.

Second, we are expanding the regulatory definition of colorectal cancer screening tests to include a complete colorectal cancer screening, where a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result.

A functional outcome of our policy for a complete colorectal cancer screening will be that, for most beneficiaries, cost sharing will not apply for either the initial stool-based test or the follow-on colonoscopy. Both of these policies reflect our desire to expand access to quality care and to improve health outcomes for patients through prevention and early detection services, as well as through effective treatments. Our revised colorectal cancer screening policies directly advance our health equity goals by promoting access for much needed cancer prevention and early detection in rural communities and communities of color that are especially impacted by the incidence of colorectal cancer. Our policies also directly support President Biden's Cancer Moonshot Goal to cut the death rate from cancer by at least 50 percent over the next 25 years and addresses his recent proclamation of March 2022 as National Colorectal Cancer Awareness Month.



## ✓ Requiring Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs 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 adding provisions that 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 the amount of discarded drug that exceeds an applicable percentage, which is required to be at least 10%, of total allowed charges for the drug in a given calendar quarter. The proposals to implement section 90004 of the Infrastructure Act included: how discarded amounts of drugs are determined; a definition of which drugs are subject to refunds (and exclusions); when and how often CMS will notify manufacturers of refunds; when and how often payment of refunds from manufacturers to CMS is required; refund calculation methodology (including applicable percentages); a dispute resolution process; and enforcement provisions. This refund applies to refundable single-dose container or single-use package drugs beginning January 1, 2023.

CMS is finalizing as proposed the definition of a refundable single-dose container or single-use package drug as a drug or biological for which payment is made under Part B and that is furnished from a single-dose container or single-use package. CMS is finalizing exclusions to this definition as required by statute for drugs that are either radiopharmaceuticals or imaging agents, drugs that require filtration during the drug preparation process, and drugs approved on or after the date of enactment of the Infrastructure Act (that is, November 15, 2021) for which payment under Part B has been made for fewer than 18 months.

For drugs with unique circumstances, CMS solicited comment on whether an increased applicable percentage would be appropriate for drug that is reconstituted with a hydrogel and administered via ureteral catheter or nephrostomy tube into the kidneys; in this circumstance, there is substantial amount of reconstituted hydrogel that adheres to the vial wall during preparation and not able to be extracted from the vial for administration. Based on comments received, CMS is finalizing an increased applicable percentage of 35 percent for this drug.

CMS also solicited comments on whether there are other drugs with unique circumstances that may warrant an increase in the applicable percentage. As a result of public comments, CMS plans to collect additional information about drugs that may have unique circumstances along with what increased applicable percentages might be appropriate for each circumstance. CMS will revisit additional increased applicable percentages through future notice and comment rulemaking.

CMS is finalizing requirements for the use of the JW modifier, for reporting discarded amounts of drugs, and the JZ modifier, for attesting that there were no discarded amounts. CMS is finalizing that providers will be required to report the JW modifier beginning January 1, 2023 and the JZ modifier no later than July 1, 2023 in all outpatient settings. In the proposed rule, CMS proposed that an initial invoice for the refund to be sent to manufacturers in October 2023. However, we believe it would be beneficial to create system efficiencies related to the reconciliation and invoicing system of the discarded drug refunds and the new inflation rebate programs under the Inflation Reduction Act, and so we are not finalizing the timing of the initial report to



manufacturers or date by which the first refund payments are due. We are, however, finalizing that we will issue a preliminary report on estimated discarded drug amounts based on claims from the first two calendar quarters of 2023 no later than December 31, 2023 and will revisit the timing of the first report in future rulemaking.

### ✓ Preventive Vaccine Administration Services

CMS finalized refinements to the payment amount for preventive vaccine administration under the Medicare Part B vaccine benefit, which includes the influenza, pneumococcal, hepatitis B, and COVID-19 vaccine and their administration. CMS finalized the proposal to annually update the payment amount for vaccine administration services based upon the increase in the MEI, and to adjust for the geographic locality based upon the geographic adjustment factor (GAF) for the PFS locality in which the preventive vaccine is administered. CMS also finalized the proposal to continue the additional payment for at-home COVID-19 vaccinations for CY 2023.

Additionally, in light of the distinction between a PHE declared under section 319 of the Public Health Service Act (PHS Act) and an Emergency Use Authorization (EUA) declaration under section 564 of the Food, Drug, and Cosmetic Act (FD&C Act), and the possibility that they will not terminate at precisely the same time, CMS is clarifying the policies finalized in the CY 2022 PFS final rule regarding the administration of COVID-19 vaccine and monoclonal antibody products, to reflect that those policies will continue through the end of the calendar year in which the EUA declaration for drugs and biological products is terminated. Lastly, CMS is finalizing the proposal to permanently cover and pay for covered monoclonal antibody products used as pre-exposure prophylaxis for prevention of COVID-19 under the Medicare Part B vaccine benefit.