

Calendar Year (CY) 2023 Medicare Physician Fee Schedule Final Rule

Nov 01, 2022

On November 01, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes updates and policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2023.

The calendar year (CY) 2023 PFS final rule is one of several rules that reflect a broader Administration-wide strategy to create a more equitable health care system that results in better accessibility, quality, affordability, and innovation.

Background on the Physician Fee Schedule

Since 1992, Medicare payment has been made under the PFS for the services of physicians and other billing professionals. Physicians' services paid under the PFS are furnished in various settings, including physician offices, hospitals, ambulatory surgical centers (ASCs), skilled nursing facilities and other post-acute care settings, hospices, outpatient dialysis facilities, clinical laboratories, and beneficiaries' homes. Payment is also made to several types of suppliers for technical services, most often in settings for which no institutional payment is made.

For most services furnished in a physician's office, Medicare makes payment to physicians and other professionals at a single rate based on the full range of resources involved in furnishing the service. In contrast, PFS rates paid to physicians and other billing practitioners in facility settings, such as a hospital outpatient department (HOPD) or an ASC, reflect only the portion of the resources typically incurred by the practitioner in the course of furnishing the service.

For many diagnostic tests and a limited number of other services under the PFS, separate payment may be made for the professional and technical components of services. The technical component is frequently billed by suppliers, like independent diagnostic testing facilities and radiation treatment centers, while the professional component is billed by the physician or practitioner.

Payments are based on the relative resources typically used to furnish the service. Relative value units (RVUs) are applied to each service for work, practice expense, and malpractice expense. These RVUs become payment rates through the application of a conversion factor. Geographic adjusters (geographic practice cost index) are also applied to the total RVUs to account for variation in practice costs by geographic area. Payment rates are calculated to include an overall payment update specified by statute.

CY 2023 PFS Ratesetting and Conversion Factor

CMS is finalizing a series of standard technical proposals involving practice expense, including the implementation of the second year of the clinical labor pricing update. We also included a comment solicitation seeking public input as we develop a more consistent, predictable approach to incorporating new data in setting PFS rates. Per statutory requirements, we are also updating the data that we use to develop the geographic practice cost indices (GPCIs) and malpractice RVUs.

With the budget neutrality adjustments, which are required by law to ensure payment rates for individual services don't result in changes to estimated Medicare spending, the required statutory update to the conversion factor for CY 2023 of 0%, and the expiration of the 3% supplemental increase to PFS payments for CY 2022, 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.

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. Similar to the approach we finalized in the CY 2021 PFS final rule for office/outpatient E/M visit coding and documentation, we 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).

We 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. We 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.

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.

Telehealth Services

For CY 2023, we are finalizing a number of policies related to Medicare telehealth services, including making several services that are temporarily available as telehealth services for the PHE available at least through CY 2023 in order to allow additional time for the collection of data that may support their inclusion as permanent additions to the Medicare Telehealth Services List. We 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 confirmed our intention to implement the telehealth provisions in sections 301 through 305 of the CAA, 2022, via program instruction or other subregulatory guidance to ensure a smooth transition after the end of the PHE. These policies, such as allowing telehealth services to be furnished in any geographic area and in any originating site setting (including the beneficiary’s home); allowing certain services to be furnished via audio-only telecommunications systems; and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services, will remain in place during the PHE for 151 days after the PHE ends. The CAA, 2022, also delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.

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>

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 and Treatment Services

We 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.

Opioid Treatment Programs (OTPs)

In order to stabilize the price for methadone for CY 2023 and subsequent years, CMS is finalizing the proposal to revise our methodology for pricing the drug component of the methadone weekly bundle and the add-on code for take-home supplies of methadone. As proposed, CMS will 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 PPI for Pharmaceuticals for Human Use (Prescription).

Additionally, based on the severity of needs of the patient population diagnosed with opioid use disorder (OUD) and receiving services in the OTP setting, CMS is finalizing the proposal to modify the payment rate for the non-drug component of the bundled payments for episodes of care to base the rate for individual therapy on a crosswalk to a code describing a 45-minute session, rather than the current crosswalk to a code describing a 30-minute session. This will increase overall payments for medication-assisted treatment and other treatments for OUD, recognizing the longer therapy sessions that are usually required.

CMS is also finalizing the proposal to allow the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with buprenorphine, to the extent that the use of audio-video telecommunications technology to initiate treatment with buprenorphine is authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) at the time the service is furnished. CMS is also finalizing the proposal to permit the use of audio-only communication technology to initiate treatment with buprenorphine in cases where audio-video technology is not available to the beneficiary, and all other applicable requirements are met.

Additionally, CMS is allowing periodic assessments to be furnished audio-only when video is not available for the duration of CY 2023, to the extent that it is authorized by SAMSHA and DEA at the time the service is furnished.

Additionally, CMS is clarifying that OTPs can bill Medicare for medically reasonable and necessary services furnished via mobile units in accordance with SAMHSA and DEA guidance. CMS is finalizing the proposal that locality adjustments for services furnished via mobile units would be applied as if the service were furnished at the physical location of the OTP registered with DEA and certified by SAMHSA.

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

Medicare payment for dental services is generally precluded by statute. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. CMS proposed to clarify and codify certain aspects of the current Medicare fee-for-services payment policies for dental services. CMS also proposed and sought comment on payment for other dental services that were inextricably linked to, and substantially related and integral to, the clinical success of, an otherwise covered medical service, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures. 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

In this rule, 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.

Updated Medicare Economic Index (MEI) for CY 2023

We proposed to rebase and revise the MEI for CY 2023 and solicited comments regarding the future use of the 2017-based MEI weights in PFS ratesetting and the GPCIs. The proposed method for determining the 2017-based MEI relies on estimating base year expenses from publicly available data from the U.S. Census Bureau NAICS 6211 Offices of Physicians. The proposed methodology allows for the use of data that are more reflective of current market conditions of physician ownership practices, rather than only reflecting costs for self-employed physicians, and also would allow for the MEI to be updated on a more regular basis since the proposed data sources are updated and published on a regular basis.

Finalizing the use of the 2017-based MEI cost weights to set PFS rates would not change overall spending on PFS services, but would result in significant distributional changes to payments among PFS services across specialties and geographies. In consideration of our ongoing efforts to update the PFS payment rates with more predictability and transparency, and in the interest of ensuring payment stability, we proposed not to use the updated MEI cost share weights to set PFS payment rates for CY 2023. However, we solicited comments on the potential use of the proposed updated MEI cost share weights to calibrate payment rates and update the GPCI under the PFS in the future.

We finalized the proposed rebasing and revising of the 2017-based MEI with some technical revisions to the proposed method based on public comments. The final CY 2023 MEI update is 3.8 percent based on the most recent historical data available. As noted above, the rebased and revised MEI weights were not used in CY 2023 PFS ratesetting.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

Chronic Pain Management and Behavioral Health Services

We are finalizing the addition of chronic pain management and behavioral health integration services to the RHC and FQHC specific general care management HCPCS code, G0511, which aligns with changes made under the PFS for CY 2023. Since the requirements for the chronic pain management and behavioral health integration services are similar to the requirements for the general care management services furnished by RHCs and FQHCs (which are the current services for which RHCs and FQHCs can use HCPCS code G0511) the payment rate for HCPCS code G0511 will continue to be the average of the national non-facility PFS payment rates for the RHC and FQHC care management and general behavioral health codes (CPT codes 99484, 99487, 99490, and 99491) and PCM codes (CPT codes 99424 and 99425) Payment will be updated annually based on the PFS amounts for these codes, which is how these updates are made currently.

Telehealth Services

We announced that we are implementing the telehealth provisions in the Consolidated Appropriations Act, 2022 (CAA, 2022) via program instruction or other subregulatory guidance to ensure a smooth transition after the end of the PHE. The CAA, 2022 extends certain flexibilities in place during the PHE for 151 days after the PHE ends, including allowing payment for RHCs and FQHCs for furnishing telehealth services as distant site practitioners (though note that mental health visits can be furnished virtually on a permanent basis) under the payment methodology established for the PHE, 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. The CAA, 2022 also delays the in-person visit requirements for mental health visits via telecommunications technology, including those furnished by RHCs and FQHCs, until 152 days after the end of the PHE.

Conforming Technical Changes to the In-Person Requirements for Mental Health Visits

We finalized conforming regulatory text changes in accordance with section 304 of the CAA, 2022 to amend paragraph (b)(3) of 42 CFR 405.2463, "What constitutes a visit," and paragraph (d) of 42 CFR 2469, "FQHC supplemental payments," to include the delay of the in-person requirements for mental health visits furnished by RHCs and FQHCs through telecommunication technology under Medicare until the 152nd day after the COVID-19 PHE ends.

Specified Provider-Based RHC Payment Limit Per-Visit

Subsequent to the publication of the CY 2022 PFS final rule, which implemented changes to the RHC payment limit as required by the Consolidated Appropriations Act, 2021, interested parties requested clarification regarding the timing of cost reports used to set the RHC payment limit. We finalized the clarification that a 12-consecutive month cost report should be used to establish a specified provider-based RHC's payment limit per visit. We believe 12-consecutive months of

cost report data accurately reflects the costs of providing RHC services and will establish a more accurate base from which the payment limits will be updated going forward.

Clinical Laboratory Fee Schedule (CLFS):

In accordance with section 4(b) of the Protecting Medicare and American Farmers from Sequester Cuts Act, we are finalizing certain conforming changes to the data reporting and payment requirements at 42 CFR part 414, subpart G. Specifically, we are finalizing revisions to § 414.502 to update the definitions of both the “data collection period” and “data reporting period,” specifying that for the data reporting period of January 1, 2023 through March 31, 2023, the data collection period is January 1, 2019 through June 30, 2019. We are also finalizing revisions to § 414.504(a)(1) to indicate that initially, data reporting begins January 1, 2017 and is required every 3 years beginning January 2023. In addition, we are finalizing conforming changes to our requirements for the phase-in of payment reductions to reflect the amendments in section 4(b) of this law. Specifically, we are finalizing revisions to § 414.507(d) to indicate that for CY 2022, payment may not be reduced by more than 0% as compared to the amount established for CY 2021, and for CYs 2023 through 2025, payment may not be reduced by more than 15% as compared to the amount established for the preceding year.

Additionally, after consideration of public comments and further analysis, we are finalizing an increase to the nominal fee for specimen collection based on the Consumer Price Index for all Urban Consumers (CPI-U). Therefore, for CY 2023, the general specimen collection fee will increase from \$3 to \$8.574 and as required by PAMA, we will increase this amount by \$2 for those specimens collected from a Medicare beneficiary in a SNF or by a laboratory on behalf of an HHA, which will result in a \$10.57 specimen collection fee for those beneficiaries. In addition, we are finalizing a policy to update this fee amount annually by the percent change in the CPI-U. We are also finalizing our proposals to codify and clarify various laboratory specimen collection fee policies in § 414.523(a)(1). This is because the policies implementing the statutory requirements under section 1833(h)(3)(A) of the Act for the laboratory specimen collection fee, which are currently described in the Medicare Claims Processing Manual Pub. 100-04, chapter 16, § 60.1., did not have corresponding regulations text and some of the manual guidance is no longer applicable.

Lastly, in light of questions we have received from interested parties, we are finalizing as proposed to codify in our regulations, and make certain modifications and clarifications to, the Medicare CLFS travel allowance policies. We are finalizing the addition of § 414.523(a)(2) “Payment for travel allowance” to reflect the requirements for the travel allowance for specimen collection. Specifically, in accordance with section 1833(h)(3)(B) of the Act, we are finalizing to include in our regulations the following requirements for the travel allowance methodology: (1) a general requirement, (2) travel allowance basis requirements, and (3) travel allowance amount requirements.

Medicare Ground Ambulance Data Collection System

CMS is finalizing a series of changes to the Medicare Ground Ambulance Data Collection System. First, we are finalizing our proposal to update our regulations at § 414.626(d)(1) and

(e)(2) to provide the necessary flexibility to specify how ground ambulance organizations should submit the hardship exemption requests and informal review requests, including to our web-based portal once that portal is operational. Second, we are finalizing our proposed changes and additional clarifications to the Medicare Ground Ambulance Data Collection Instrument. The changes and clarifications aim to reduce burden on respondents, improve data quality, or both. We grouped these changes and clarifications into four broad categories: editorial changes for clarity and consistency; updates to reflect the web-based system; clarifications responding to feedback from questions from interested parties and testing; and typos and technical corrections.

Origin and Destination Requirements Under the Ambulance Fee Schedule

CMS is finalizing our interim final policy (85 FR 19276) that the expanded list of covered destinations for ground ambulance transports was for the duration of the COVID-19 PHE only. These destinations include, but are not limited to, any location that is an alternative site determined to be part of a hospital, critical access hospital(CAH)or skilled nursing facility (SNF), community mental health centers, Federally qualified health centers, rural health clinics, physician offices, urgent care facilities, ambulatory surgical centers, any location furnishing dialysis services outside of an end-stage renal disease (ESRD) facility when an ESRD facility is not available, and the beneficiary's home.

When the COVID-19 PHE ends, our regulations will reflect the long-standing ambulance services coverage for the following destinations only: hospital; CAH; SNF; beneficiary's home; and dialysis facility for an ESRD patient who requires dialysis. In addition to these long-standing covered destinations, rural emergency hospitals (REH) will also be an allowed destination, in accordance with the Consolidated Appropriations Act, 2021, effective with services on or after January 1, 2023.

For a fact sheet on the CY 2023 Quality Payment Program changes, please visit (clicking link downloads zip file): <https://qpp-cm-prod-content.s3.amazonaws.com/uploads/2136/2023%20Quality%20Payment%20Program%20Final%20Rule%20Resources.zip>

For a fact sheet on the Medicare Shared Savings Program changes, please visit: <https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule-medicare-shared-savings-program>

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