

Calendar Year (CY) 2023 Medicare Physician Fee Schedule

Proposed Rule

On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a proposed rule that announces and solicits public comments on proposed 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 proposed rule is one of several proposed 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 a variety of 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

We are proposing a series of standard technical proposals involving practice expense, including the implementation of the second year of the clinical labor pricing update. We have also included a comment solicitation seeking public input as we develop a more consistent, predictable approach to incorporating new data in setting PFS rates. We hope to implement changes that will promote transparency and predictability in payment amounts. **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, as 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% increase in PFS payments for CY 2022, **the proposed CY 2023 PFS conversion factor is \$33.08, a decrease of \$1.53 to the CY 2022 PFS conversion factor of \$34.61.**

Updated Medicare Economic Index (MEI) for CY 2023

We are proposing to rebase and revise the MEI cost share weights for CY 2023. We are soliciting comments regarding the rebasing and revision of the MEI, which measures the input price pressures of providing physician services. We are proposing a new methodology for estimating base year expenses that relies on publicly available data from the U.S. Census Bureau NAICS 6211 Offices of Physicians. This 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 will allow for the MEI to be updated on a more regular basis.

Using the new MEI cost weights to set PFS rates would not change overall spending on PFS services, but would likely result in significant changes to payments among PFS services. In consideration of our ongoing efforts to update to the PFS payment rates with more predictability and transparency, and in the interest in ensuring payment stability, **we are proposing not to use the proposed updated MEI cost share weights to set PFS payment rates for CY 2023.** However, we are soliciting 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.

Comment Solicitation on Global Surgical Services

We are soliciting public comment on strategies for improving global surgical package valuation and paying more accurately for the global surgical packages under the PFS.

Evaluation and Management (E/M) Visits

As part of the ongoing updates to E/M visits 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 are proposing to adopt most of these 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 would include 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 are proposing 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 are also proposing to create 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.

Request for Information: Medicare Potentially Underutilized Services

In this rule, we seek to engage with interested parties and stakeholders and solicit comment regarding ways to identify and improve access to high value, potentially underutilized services by Medicare beneficiaries.