



ACEP's First Take from the Combined 2023 Medicare Physician Fee Schedule (PFS) and MACRA Quality Payment Program (QPP) Final Rule

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) released a [Medicare annual payment rule](#) for calendar year (CY) 2023 that impacts payments for physicians and other health care practitioners. The rule combines policies for the Medicare physician fee schedule (PFS) with those for the Quality Payment Program (QPP)—the quality performance program established by the Medicare Access and CHIP Reauthorization Act (MACRA). CMS had issued a [proposed rule](#) in July, which ACEP [responded to](#) with a robust set of comments. Below is a high-level summary of key final policies.

Physician Fee Schedule

- **Conversion Factor:** Due to CMS' decision to increase the office and outpatient evaluation and management (E/M) services in 2021, there is a budget neutrality adjustment, as required by law. This requirement under the Medicare PFS forces CMS to make an overarching negative adjustment to physician payments to counterbalance any increases in code values that CMS implements. CMS usually does this by adjusting the Medicare "conversion factor" which converts the building blocks of PFS codes (relative value units or RVUs) into a dollar amount. Congress has been able to offset the majority of the budget neutrality cut that was expected to go into place both in 2021 and 2022. Most recently, Congress added back 3.0 percent to the conversion factor. Now, going into 2023, Congress needs to act again, or the conversion factor will be cut by that same 3.0 percent.

The final CY 2023 PFS conversion factor reflects the looming 3.0 percent cut (and other RVU adjustments)—and is \$33.0607, a decrease of \$1.5455 or 4.5 percent from the CY 2022 PFS conversion factor of \$34.6062. Emergency medicine reimbursement in 2023 is expected, on average, to be neutral, EXCEPT for the across-the-board reduction of 3.0 percent.

In the rule, CMS is finalizing its proposal to rebase and revise the Medicare Economic Index (MEI) cost share weights in CY 2023. The MEI is traditionally used to affect the relative weights of the three components in payments under the PFS—work, practice expense (PE), and malpractice. However, CMS has decided not to use the updated MEI cost share weights to set PFS payment rates for CY 2023. If it did, emergency medicine reimbursement would be cut by 7 percent.

- **Split or Shared Services:** In last year's rule, CMS finalized a policy for determining whether a physician or non-physician practitioner should bill for an E/M service that they both were involved in delivering (called split/shared services). Under Medicare, a service can only be billed by one clinician, and if non-physician practitioners wind up billing for a service, they only receive 85 percent of the total Medicare rate.

The finalized policy from last year's rule applies only to E/M services delivered in facilities (including the emergency department)—and excludes critical care. The key here is deciding who provides the "substantive" portion of the service. CMS decided to phase in the policy — in 2022, the history, physical exam, medical decision making (MDM), *or* more than half of the total time spent with a patient can be used to determine the substantive portion of the split/shared visit.

However, CMS initially stated that starting in 2023, only *time* will be used for the purposes of determining the substantive portion of a split/shared visit.

ACEP, the American Medical Association (AMA), and many other specialty societies strongly oppose using only time to determine the substantive portion of a split/shared E/M service and have [formally requested](#) that CMS reverse its 2023 policy and instead modify it to allow the determination to be made based on time OR MDM.

In this year's rule, CMS is finalizing its proposal to delay the implementation of the full transition to time only until 2024. CMS will continue to allow providers to use the history, physical exam, medical decision making (MDM), or more than half of the total time spent with a patient to determine the substantive portion of the split/shared visit in 2023.

Emergency Department (ED) Evaluation and Management (E/M) Codes: The AMA released the 2023 Documentation Guideline changes on its website on July 1, 2022. The guidelines are available [here](#).

The ACEP Current Procedural Terminology (CPT) team was successful in our primary goals of keeping all five current levels of ED E/M codes going forward and, most importantly, preventing time from introduction as a descriptive element of ED codes. It is important to note that ACEP is the *only* representative of emergency medicine in the CPT and AMA Relative Value Scale Update Committee (RUC) processes, and it was ACEP's advocacy that resulted in these positive changes.

Starting in January 2023, ED code levels will be determined based on MDM only. A medically appropriate history and physical exam should be documented, but those will not be considered in determining the level of E/M service assigned. The 2023 ED E/M code descriptors will look like this:

- 99281 - Emergency department visit for the evaluation and management of a patient, that may not require the presence of a physician or other qualified health care professional
- 99282 - Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making
- 99283 - Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making
- 99284 - Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making
- 99285 - Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making

A new MDM grid was published that applies to all E/M services. We were not successful in getting an emergency medicine-specific MDM grid, but we did get a few tweaks that might help our

members, including getting credit for diagnostic tests considered but not ordered and for the decision regarding hospitalization or escalation of hospital level care. Also, there will now be language specific to diagnosis or treatment significantly limited by social determinants of health.

ED E/M Level 4 Code

The current work relative value unit (RVU) for the ED E/M Level 4 service (CPT 99284) is 2.74. CMS had increased the work RVU to 2.74 from 2.60 in 2021 after ACEP persuaded CMS that it should maintain the relativity in service levels between the ED E/M codes and the office and outpatient E/M codes. Based on an AMA RUC survey, the AMA RUC recommended that the work RVU should drop back down to 2.60 starting in 2023. CMS is finalizing its proposal to **REJECT** the AMA RUC recommendation, and instead is continuing to rely on ACEP's previous argument that the ED E/M codes should retain their relative values as compared to the office and outpatient E/M codes in order to reflect their higher typical intensity.

This final policy is significant since the ED E/M level 4 service is one of the most commonly billed codes among emergency physicians. A decrease in the work RVU from 2.74 to 2.60 would, on the whole, have reduced emergency medicine reimbursement by tens of millions of dollars.

AMA Documentation Guidelines

In the rule, CMS discusses the AMA CPT documentation changes and has adopted most of these changes in coding and documentation. However, CMS is maintaining the **current** billing policies that apply to the E/M codes while the agency considers potential revisions that might be necessary in future rulemaking.

For more information on the documentation guidelines, please review [ACEP's Frequently Asked Questions](#).

Critical Care Services

CMS is finalizing its proposal to change the threshold for reporting CPT 99292 in addition to the base code of CPT 99291 from 75 minutes to 104 minutes. ACEP had strongly opposed this critical care policy as it differs from long-standing CPT policy, and we believe it will increase confusion among clinicians and increase administrative burden.

Observation Services

CMS is finalizing its proposal to accept the CPT coding changes that merge the codes previously describing observation services into the inpatient E/M code set. CMS is not delaying the implementation of this transition, and it will become effective as of January 1, 2023. CMS is also finalizing the proposed values for these services.

Billing For Both an ED Service and An Observation Service: CMS is finalizing its proposal to retain the policy that a billing provider may only bill initial hospital or observation care service if the physician sees a patient in the ED and decides to either place the patient in observation status or admit the patient as a hospital inpatient, in contradiction to the CPT policy.

8-to-24-Hour Rule: The 8-to-24-hour rule is the policy that applies when observation services transcend a calendar date. CMS is continuing to apply this policy but provides some clarifications based on public comments. CMS also states that the 24-hour rule is distinct from the “23-hour rule” and the “two midnight rule.” In light of the consolidation of the Hospital Inpatient and Observation Care code sets, CMS will review how these policies interact and looks forward to further engagement with the public.

Prolonged Services: CMS is rejecting the CPT recommendation to adopt CPT code 99418, as CMS believes that the billing instructions for CPT code 99418 would lead to administrative complexity, potentially duplicative payments, and limit our ability to determine how much time was spent with the patient using claims data. Instead, CMS will create a single G-code, G0316, that describes prolonged inpatient or observation services.

- **Telehealth:** In previous PFS rules, CMS has examined which of the codes that are temporarily on the list of approved Medicare telehealth services during the COVID-19 public health emergency (PHE) would remain on the list for an extended period or permanently.

CMS added all five ED E/M code levels 1-5 (CPT codes 99281-99285), the critical care codes, and some observation codes to the approved telehealth list through December 31, 2023. The codes were added to the telehealth list on a special “Category 3” basis that CMS added for the PHE. CMS did note that it still needs to see more data and evidence about the benefits of providing ED E/M, critical care, and observation services via telehealth in order to permanently add these codes to the list of approved telehealth services.

In this year’s rule, CMS does not make any changes to the status of the ED E/M codes but does add more codes to the telehealth list on a Category 3 basis. All codes added on a Category 3 basis will continue to be included on the telehealth list through the end of CY 2023. In the event that the PHE extends well into CY 2023, CMS may consider revising this policy.

There were some other codes that CMS had previously added to telehealth list that were set to be removed once the PHE ended. CMS is keeping those codes on the list for an additional 151 days after the PHE. This 151-day extension aligns with the Consolidated Appropriations Act, 2022 (CAA, 2022), which extended the Medicare originating site and geographic restriction waivers for a 151-day period once the PHE ends. CMS is also implementing the CAA, 2022 provision that delayed the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.

- **Dental and Oral Health Services:** The traditional Medicare program (also known as Medicare Fee-for-Service or FFS) currently covers a limited set of dental services. In the rule, CMS clarifies and codifies certain aspects of the current Medicare FFS payment policies for dental services. CMS is also finalizing its proposals related to payment for other dental services that are substantially related and integral to the clinical success of an otherwise covered medical service. Furthermore, CMS is 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.

- **The Medicare Shared Savings Program:** The Medicare Shared Savings Program is the national accountable care organization (ACO) program, which serves over 11 million Medicare beneficiaries. In the rule, CMS is finalizing numerous changes to the program that CMS had proposed in the proposed rule, including:
 - Allowing for upfront advanced payments to be made to certain new Medicare Shared Savings Program ACOs that could be used to address Medicare beneficiaries' social needs;
 - Giving smaller ACOs more time to transition to downsize financial risk;
 - Creating a health equity adjustment to an ACO's quality performance category score to reward excellent care delivered to underserved populations; and
 - Adjusting the benchmark methodology to encourage more ACOs to participate.
- **Behavioral Health and Chronic Pain Management Services:** To help improve access to behavioral health services, CMS is finalizing its proposal to allow licensed professional counselors, marriage and family therapists, and other types of behavioral health practitioners to provide behavioral health services under general (rather than direct) supervision. In addition, CMS is finalizing its proposal to create a new behavioral health integration service category, allowing payment for clinical psychologists and licensed clinical social workers who provide integrated behavioral health services as part of a patient's primary care team.

With respect to chronic pain management, CMS is finalizing its proposal to create new codes to better account for the time needed to manage patients with chronic pain.

- **Opioid Treatment Programs (OTPs):** CMS is allowing OTPs to initiate treatment of buprenorphine via two-way audio-video communications technology, as long as that method of providing care is authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA). The DEA and SAMHSA currently have temporary telehealth policies in place. CMS will also allow the service to be performed via audio-only communication technology if two-way audio-video communications technology is not available. CMS is also clarifying that OTPs can bill Medicare for medically reasonable and necessary services furnished via mobile units.

Merit-based Incentive Payment System (MIPS)

CMS introduces policies that impact the seventh performance year (2023) of the Quality Payment Program (QPP). The QPP includes two tracks: the [Merit-based Incentive Payment System \(MIPS\)](#) and Advanced Alternative Payment Models (APMs). MIPS includes four performance categories: Quality, Cost, Improvement Activities, and Promoting Interoperability (formerly Meaningful Use). Performance on these four categories (which are weighted) roll up into an overall score that translates to an upward, downward, or neutral payment adjustment that providers receive two years after the performance period (for example, performance in 2023 will impact Medicare payments in 2025).

- **2022 Reporting Exemptions Due to COVID-19:** As described [here](#), CMS is granting hardship exemptions on a case-by-case basis due to COVID-19. It is therefore possible for a clinician or group to request to be exempted from all four performance categories in 2022. If clinicians submit a hardship exception application for all four MIPS performance categories, and their application is approved, they will be held harmless from a payment adjustment in 2024—meaning that they will not be eligible for a bonus or potentially face a penalty based on their MIPS performance in 2022. CMS has also granted hardship exemptions for Florida and Puerto Rico, which were hit by

natural disasters.

- **MVPs:** The 2023 performance year is first year of a new reporting option in MIPS called MIPS Value Pathways (MVPs). MVPs represent an approach that will allow clinicians to report on a uniform set of measures on a particular episode or condition in order to receive MIPS credit. *ACEP developed an emergency medicine-focused MVP that CMS will be including in the first batch of MVPs starting in 2023.* There were six other MVPs that CMS previously finalized in last year’s rule (for a total of seven).

In this year’s rule, CMS is finalizing small adjustments to the emergency medicine-focused MVP: removing 2 improvement activities based on updates to the improvement activities inventory and adding one improvement activity. CMS is also creating five new MVPs that would start in 2023 in addition to the seven that the agency had already finalized.

CMS is also expanding the opportunities for the public to provide feedback on potential MVPs and to recommend changes to existing MVPs. With respect to existing MVPs, CMS will host an annual public webinar to discuss potential MVP revisions that have been identified.

- **Performance Category Weighting in Final Score:** CMS is maintaining the same performance category weights as in 2022. The weights are required by law.

General Performance Category Weights Finalized for 2023:

- Quality: 30%
- Cost: 30%
- Promoting Interoperability (EHR): 25%
- Improvement Activities: 15%

- **The Performance Threshold:** CMS is finalizing its proposal keep the threshold that clinicians need to achieve to avoid a penalty at 75 points in 2023—the same threshold the agency established in 2022. By law, CMS has to set the performance threshold at the mean or median of a prior performance year and decided to pick the same year (2017) that it did when setting the 2022 performance threshold.

- There is no exceptional bonus threshold starting in the 2023 performance period. The 2022 performance period (which impacts payments in 2024) was the last year the additional funding for exceptional performance was available.

- **Qualified Clinical Data Registries (QCDRs):** ACEP owns and operates its own QCDR, the [Clinical Emergency Data Registry \(CEDR\)](#). In the rule, CMS is finalizing its proposal to delay the QCDR measure testing requirement for traditional MIPS by an additional year, until the CY 2024 performance period/2026 MIPS payment year. However, CMS is not changing the requirements that QCDR measures be fully tested prior to inclusion in an MVP.

- **Other MIPS Proposals:** CMS is also finalizing the following proposals:
 - Maintain the data completeness threshold at 70 points in CY 2023 and increase the data completeness criteria threshold from 70 percent to 75 percent for the CY 2024 and 2025 performance periods/2026 and 2027 MIPS payment years.
 - Expand the definition of “high priority measure” to include health equity-related quality measures.

- Score administrative claims measures exclusively against performance period benchmarks.
 - Reduce the inventory of quality measures from 200 to 198 through the removal of 11 and the addition of 9 MIPS quality measures (a net decrease of 2 quality measures).
 - Add 4 new improvement activities, modify 5 existing improvement activities, and remove 6 existing improvement activities.
 - Establish a maximum cost improvement score of 1 percentage point out of 100 percentage points available for the cost performance category starting with the CY 2022 performance period/2024 MIPS payment year.
 - Allow those who use the facility-based scoring option (including emergency physicians) to be eligible to receive the complex patient bonus, even if they do not submit data for at least one MIPS performance category.
 - Make the following adjustments to the Promoting Interoperability Category: (1) Requiring and modifying the Electronic Prescribing Objective's Query of Prescription Drug Monitoring Program (PDMP) measure while maintaining the associated points at 10 points; (2) Expanding the Query of PDMP measure to include not only Schedule II opioids, but also Schedule III, and IV drugs; (3) Adding a new Health Information Exchange (HIE) Objective option, the Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA) measure, as an optional alternative to fulfill the objective; (4) Consolidating the current options from three to two levels of active engagement for the Public Health and Clinical Data Exchange Objective; (5) Modifying the overall scoring methodology; and (6) Continuing to reweight the Promoting Interoperability performance category for certain types of non-physician practitioner MIPS eligible clinicians.
 - Allowing a facility-based MIPS eligible clinician to receive the complex patient bonus, even if they don't submit data for at least one MIPS performance category.
- **APM Policies:** CMS is creating several policies to reduce burden and facilitate participation in Advanced APMs. CMS is removing the 2024 expiration of the 8 percent minimum on the Nominal Risk standard for Advanced APMs and making the 8 percent minimum permanent. CMS is also applying the 50 eligible clinician limit to the APM Entity participating in the Medical Home Model.