

**Medicare Physician Fee Schedule Final Rule for Calendar Year 2023
Detailed Summary of the Payment and Quality Payment Program Provisions**

The American College of Radiology (ACR) has prepared this detailed analysis of final changes to the Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2023. These rule changes are effective Jan. 1, 2023.

Conversion Factor and CMS Overall Impact Estimates (Page 2264)

CMS finalized a CY 2023 conversion factor of \$33.0607 compared to the 2022 conversion factor of \$34.6062. This was calculated by first removing the one-year 3 percent increase provided by the Protecting Medicare and American Farmers from Sequester Cuts Act and then applying a negative 1.60 percent budget neutrality update. The budget neutrality update is largely related to increased values for several evaluation and management code families, including hospital, emergency medicine, nursing facility and home visits.

TABLE 146: Calculation of the CY 2023 PFS Conversion Factor

CY 2022 Conversion Factor		34.6062
Conversion Factor without CY 2022 Protecting Medicare and American Farmers from Sequester Cuts Act		33.5983
Statutory Update Factor	0.00 percent (1.0000)	
CY 2023 RVU Budget Neutrality Adjustment	-1.60 percent (0.9840)	
CY 2023 Conversion Factor		33.0607

CMS estimates an overall impact of the MPFS changes to radiology to be a 2 percent decrease, while interventional radiology would see an aggregate decrease of 3 percent, nuclear medicine a 2 percent decrease and radiation oncology and radiation therapy centers a 1 percent decrease. The decrease is due changes in relative value units (RVUs) and the second year of the transition to clinical labor pricing updates in addition to the 1.60 percent budget neutrality conversion factor decrease.

If Congress does not intervene to extend the 3 percent increase provided by the Protecting Medicare and American Farmers from Sequester Cuts Act, the percent decreases mentioned above will be greater for CY 2023. The American Medical Association (AMA) estimates total decreases of 5 percent for radiology, 6 percent for interventional radiology, 5 percent for nuclear medicine and 4 percent for radiation oncology and radiation therapy centers without Congressional action.

Updates to Prices for Existing Direct Practice Expense (PE) Inputs (Page 34)

Over a four-year period, CMS updated the prices for over 1300 medical supplies and 750 equipment inputs. The phase-in period ended in 2022.

In the proposed rule, CMS shared that they received invoices for several supply and equipment items from stakeholders. Based on submissions, CMS proposed to update the prices for eight supplies and two equipment items, including SK082 – *towel, paper (Bounty)(per sheet)*, which is accounted for in the practice expense of several Radiology codes. CMS proposed to increase the price by 114%, from \$0.007 to \$0.015. CMS also received invoices for an additional eight supplies and two equipment items for which they did not propose pricing updates. These items do not pertain to Radiology.

In the final rule, CMS stated that they received support to proceed with updating the prices for the eight supplies and two equipment items they proposed. For the additional eight supplies and two equipment items that they did not update pricing for, CMS provided their rationale for not doing so.

CMS also received comments supporting the creation of an alternative injection pack that utilizes Chloraprep (chlorhexidine) for intact skin preparation instead of Betadine (povidone-iodine solution). The current basic injection pack (SA041) with Betadine will remain, while an alternate injection pack (SA135) with Chloraprep has been created for future use. SA135 will be priced at \$14.12.

CMS continues to welcome stakeholder feedback on the updated pricing of supplies and equipment and will consider any new invoices submitted during rulemaking or outside the comment timeline via email at PE_Price_Input_Update@cms.hhs.gov.

Clinical Labor Pricing Update (Page 47)

2022 marks the final year of the supplies and equipment pricing phase-in and the first year of the clinical labor pricing update. The pricing for clinical labor staff had not been updated since 2002. The four-year phase-in of updated pricing for clinical labor staff will last from 2022-2025. Data from the Bureau of Labor Statistics (BLS) is the primary source of clinical labor pricing information, however, CMS also crosswalked or extrapolated wages from other sources such as Salary Expert. CMS also considers data submitted by stakeholders to assist with the pricing updates.

For CY 2023, CMS is making changes to several clinical labor staff types that impact Radiology. CMS is updating the clinical labor description for the Angio Technician (L041A) to “Vascular Interventional Technologist” based on comments they received. Additionally, following the proposed rule, CMS received wage data from the 2022 Radiologic Technologist Wage and Salary Survey, which they are using to update the final pricing for several staff types: The Vascular Interventional Technologist (L041A) is increasing from \$0.60 to \$0.84 per minute, the Mammography Technologist (L043A) is increasing from \$0.63 to \$0.79 per minute, and the CT Technologist (L046A) is increasing from \$0.76 to \$0.78 per minute. The BLS did not contain wage data for these specific clinical staff types, and they were previously valued via a crosswalk methodology. While data was also submitted for the MRI Technologist (L047A), the BLS

contains wage data for this clinical staff type, and CMS believes that the BLS is the most accurate source of information for wage data.

CMS continues to welcome stakeholder feedback on the clinical labor rates.

Potentially Misvalued Services Under the PFS (Page 93)

In the proposed rule, 20 codes were publicly identified as potentially misvalued, none of which pertain to radiology. CMS finalized their decision to not adopt any of the codes as potentially misvalued for re-review.

Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology (Page 64)

In the proposed rule, CMS asked stakeholders for comments on how to improve the collection of PE data inputs or how to refine the PE methodology. CMS acknowledged that some of the data for indirect PE inputs (rent, IT costs, and non-clinical expense) are over a decade old and would benefit from routine updates in order to avoid unpredictable shifts in payment. The most recent data on indirect PE data inputs was last collected via the 2007 and 2008 Physician Practice Information Survey (PPIS) performed by the AMA.

CMS had contracted with RAND to assess potential improvements to the current PE methodology, with the goal of moving toward a more standardized and routine approach to indirect PE valuation.

In the final rule, CMS shared that many commenters requested that CMS delay any change to the indirect PE inputs, as the AMA is in the process of collecting this data—similar to their 2007 and 2008 efforts. The AMA believes they will have data available to share by early CY 2024. CMS has relied on the AMA’s physician cost data for over 50 years and has stated that the AMA’s PPIS has been the best available source of data calculating indirect PE.

CMS states that the AMA’s timeline has the potential to delay a refresh of the indirect PE data by several years, which is at odds with some stakeholders’ request for CMS to better reflect costs in the changing healthcare payment landscape. While CMS is not moving forward with any changes to the PE methodology in CY 2023, the Agency stresses the importance of transparency and repeatability in any future methodology for updating the indirect PE inputs. CMS will continue to consider alternative methods of updating indirect PE inputs, such as data already in the public domain that is verifiable and objective. CMS appreciates the feedback they have received and will continue to consider possible proposals in future rulemaking.

Potentially Misvalued Services Under the PFS (Page 93)

About 20 codes were publicly identified as potentially misvalued; however, none of the codes pertain to radiology.

Valuation of Specific Codes for CY 2023 (Page 179)

Percutaneous Arteriovenous Fistula Creation (CPT codes 36836 and 36837) (Page 235)

Two new codes for Percutaneous Arteriovenous Fistula Creation were created by the CPT Editorial Panel: 36836 (*Percutaneous arteriovenous fistula creation, upper extremity, single access of both the peripheral artery and peripheral vein, including fistula maturation procedures (e.g., transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation*) and 36837 (*Percutaneous arteriovenous fistula creation, upper extremity, separate access sites of the peripheral artery and peripheral vein, including fistula maturation procedures (e.g., transluminal balloon angioplasty, coil embolization) when performed, including all vascular access, imaging guidance and radiologic supervision and interpretation*). CPT codes 36836 and 36837 represent two percutaneous approaches to creating arteriovenous access for End-Stage Renal Disease (ERSD) patients during hemodialysis. These codes would replace HCPCS codes G2170 and G2171.

In the proposed rule, CMS did not agree with the RUC-recommended values (7.50 RVU for CPT code 36836 and 9.60 RVU for CPT code 36837), believing the values are high relative to other codes with similar intra-service time.

CMS also solicited for additional information regarding pricing and typicality for two equipment items and four supply items: Ellipsys EndoAVF generator (EQ404), Wavelinq EndoAVF generator (EQ403), SD149 (catheter, balloon inflation device), SD152 (catheter, balloon, PTA), SF056 (detachable coil), and SF057 (non-detachable embolization coil) in relation to the typicality of these supply items and how often they are used in these procedure(s).

In the final rule, despite stakeholder comments supporting the RUC-recommended values, CMS indicated they will move forward with their refined values for the codes: of 7.20 RVU for CPT code 36836, and 9.30 RVU for CPT code 36837, based on intra-service time ratio calculations. Although CMS did not agree with the RUC-recommended values, the Agency acknowledged that the use of an incremental difference between these CPT codes (at 2.10 RVUs) is a valid methodology for setting values, especially in valuing services within a family of codes where it is important to maintain an appropriate intra-family relativity. CMS also finalized the deletion of HCPCS codes G2170 and G2171, which will be replaced by CPT codes 36836 and 36837.

After reviewing the information provided by the commenters, who indicated that the four supply items and two equipment items are typically used in the procedures described CPT codes 36836 and 36837, CMS finalized the direct PE inputs as recommended by the RUC without refinement. CMS did indicate that they received an invoice for Ellipsys[™] Vascular Access Catheter (SD351) pricing it at \$8,950 compared to the \$6,000 invoice submitted to the RUC in January 2022. However, CMS would like additional feedback before making the substantial pricing increase, and will consider this information in future rulemaking.

Somatic Nerve Injections (CPT codes 64415, 64416, 64417, 64445, 64446, 64447, 64448, 76942, 77002, and 77003) (Page 278)

At the October 2018 RUC, it came to light that the somatic nerve injection codes, 64415 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed*), 64416 (*Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed*), 64417 (*Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed*), 64445 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed*), 64446 (*Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed*), 64447 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed*), and 64448 (*Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement), including imaging guidance, when performed*) were reported over 50 percent of the time with imaging code 76942 (*Ultrasonic guidance for needle placement, imaging supervision and interpretation*). These codes were presented at the October 2021 RUC meeting, along with CPT code 77002 (*Fluoroscopic guidance for needle placement*) and CPT code 77003 (*Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)*).

In the proposed rule, CMS proposed refinements to several CPT codes in the somatic nerve injection family (64415, 64416, 64445, and 64446), while supporting the RUC recommendations for the remaining codes in the family.

In the final rule, following stakeholder feedback, CMS changed their minds and finalized the RUC-recommended values for all codes in the somatic nerve injection family, as well as the imaging CPT codes: 77002 (work RVU of 0.54), 77003 (work RVU of 0.60), and 76942 (work RVU of 0.67). CMS also accepted the direct PE inputs for all of the codes as recommended by the RUC.

Contrast X-Ray of Knee Joint (CPT Code 73580) (Page 302)

CPT code 73580 (*Radiologic examination, knee, arthrography, radiological supervision and interpretation*) was first identified via the high-volume growth screen in 2008. In 2021, the Relativity Assessment Workgroup (RAW) noted that code 73580 was never surveyed and remains CMS/Other-sourced and recommended that it be surveyed for the October 2021 RUC meeting.

For CY 2023, CMS is finalizing their proposal to accept the RUC-recommended work RVU of 0.59 as well as the RUC-recommended direct PE inputs without refinement.

3D Rendering with Interpretation and Report (CPT Code 76377) (Page 303)

CMS nominated CPT code 76377 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; requiring image postprocessing on an independent workstation*) in the CY 2020 PFS final rule as potentially misvalued. The Agency believe it is in the same family as CPT code 76376 (*3D rendering with interpretation and reporting of computed tomography, magnetic resonance imaging, ultrasound, or other tomographic modality with image postprocessing under concurrent supervision; not requiring image postprocessing on an independent workstation*), which was recently reviewed at the April 2018 RUC, and requested that CPT code 76377 be reviewed to maintain relativity.

Recommendations for CPT code 76377 were presented at the October 2021 RUC meeting. Despite a 5-minute reduction in physician total time, the RUC determined that changes in technique and patient population support the maintaining of value at 0.79 RVU. For CY 2023, CMS finalized the RUC-recommended work RVU of 0.79. However, the Agency continues to believe that CPT code 76376 and 76377 would be more appropriately viewed as belonging to the same code family and request that they be surveyed together. The specialty societies have maintained that these services should be considered separate and not part of the same family. CMS is also finalizing the RUC-recommended direct PE inputs without refinement.

Neuromuscular Ultrasound (CPT codes 76881, 76882, and 76883) (Page 304)

A new code for Neuromuscular Ultrasound was created by the CPT Editorial Panel: 76883 (*Ultrasound, nerve(s) and accompanying structures throughout their entire anatomic course in one extremity, comprehensive, including real-time cine imaging with image documentation, per extremity*). The code family was expanded to include CPT codes 76881 (*Ultrasound, complete joint (ie, joint space and periarticular soft-tissue structures), real-time with image documentation*) and 76882 (*Ultrasound, limited, joint or focal evaluation of other nonvascular extremity structure(s) (eg, joint space, peri-articular tendon[s], muscle[s], nerve[s], other soft-tissue structure[s], or soft tissue mass[es]), real-time with image documentation*). This family of three codes was presented at the January 2022 RUC meeting.

In the CY 2023 MPFS proposed rule, CMS proposed refinements to the RUC-recommended work RVUs for CPT codes 76881, 76882, and 76883, stating that the RUC-recommended values did not account for changes in the survey time. CMS instead applied a reverse building block methodology to reach their proposed work RVUs for the code family. Additionally, the Agency recommended the removal of 5 minutes of pre-service evaluation time and 5 minutes of immediate post-service time for CPT code 76881 based on the rationale that this code is reportedly billed with an E/M code.

With regard to the PE inputs, CMS also proposed to remove 2 minutes of clinical labor time for CA006 (*Confirm availability of prior images/studies*), 1 minute of clinical labor time for the CA007 (*Review patient clinical extant information and questionnaire*), and 2 minutes for CA011

(Provide education/obtain consent) for CPT code 76881, as they believed there was overlap with the E/M visit that is typically billed with CPT code 76881.

In the final rule, CMS received several comments related to their refinements to this code family. Stakeholders argued that the pre- and post-service work associated with musculoskeletal ultrasound is much more detailed and time intensive than the minutes typically associated with an E/M visit. CMS agreed with stakeholders that the clinical activities performed during that time are different and are finalizing the RUC-recommended physician work time, with 5 minutes of pre-time and 5 minutes of post-time for CPT code 76881. CMS will be finalizing the RUC-recommended values of 0.90 RVU, 0.69 RVU, and 1.21 RVU for CPT codes 76881, 76882, and 76883, respectively.

CMS will also be finalizing the PE inputs as recommended by the RUC, including the minutes for CA006, CA007, and CA011, as they now agree with stakeholders that there is no overlap with the E/M visit. CMS also received comment from rheumatologists stating that they have a dedicated ultrasound room even with the use of a portable ultrasound unit, as well as a PACS system. Some commenters even submitted their own survey data that differed from the RUC recommendations. These comments led CMS to encourage RUC re-review of the PE inputs for this code family using the latest Medicare claims data to determine dominant specialty, and to collect and submit updated invoices, as appropriate.

In the CY 2023 Addendum B, it was noted that -TC and -26 reimbursement for these codes was not available, making it not separately billable by a technician. The involved specialties are in communication with CMS in an effort to resolve any misunderstanding related to this change.

Evaluation and Management (E/M) Visits (Page 498)

Background

CMS has participated in a multi-year effort with the AMA and other interested parties to update coding and payment E/M visits to reflect the current practice of medicine, reduce practitioner burnout, and paid accurately under the PFS. Effective January 1, 2021, the CPT Editorial Panel redefined the office/outpatient O/O E/M visits so that the visit level is selected based on time spent performing the visit or the level of medical decision-making (MDM) as redefined in the CPT E/M Guidelines. History of present illness and a physical exam are no longer required elements of these services or used to select the O/O E/M visit level. Also, the CPT Editorial Panel revised the O/O E/M visit descriptor times and the CPT E/M Guidelines.

CMS accepted the revised CPT codes and approach for the O/O E/M visits but did not accept the revisions for prolonged O/O services. CMS created G2212 for reporting of prolonged O/O E/M services and add-on code G2211 (*office/outpatient E/M visit complexity*) that can be reported in conjunction with O/O E/M visits. The Consolidated Appropriations Act (CAA), 2021 imposed a moratorium on Medicare payment for these services by prohibiting CMS from making payment under the physician fee schedule for HCPCS code G2211 before January 1, 2024.

For 2023, the AMA CPT Editorial Panel has revised the remaining E/M visit code families (except critical care services) to match the framework of the O/O E/M visits where visit level will be selected based on the amount time spent with the patient or the level of MDM as redefined in the CPT E/M Guidelines. History and physical exam will only be considered when and to the extent that they are medically appropriate and will no longer impact the Other E/M visit level. This revision also consolidated the Other E/M codes by combining inpatient and observation visits into a single code set and also combining home and domiciliary visits into a single code set; this reduced the Other E/M CPT codes from approximately 75 to approximately 50 codes.

CMS stated that under the PFS, Other E/M visits will have a significant impact on relative resource valuation. E/M visits make up approximately 40 percent of all allowed charges under the PFS. The subset of Other E/M visits comprises approximately 20 percent of all allowed charges. CMS finalized the technical correction to the placement of its regulation text for split (or shared) visits, and to delay implementation of the policy to define the substantive portion of a split (or shared) visit based on the amount of time spent by the billing practitioner until January 1, 2024. They finalized a technical correction regarding how time is reported for split (or shared) critical care visits.

Overview of Policy Proposals

CMS finalized its proposal to adopt the new and revised CPT codes and descriptors for Other E/M visits, except for prolonged services. Prolonged Other E/M services would be reported under one of three HCPCS G codes. CMS also finalized its proposal to generally adopt the revised CPT E/M Guidelines for Other E/M visits including the guidelines for determining level of MDM and selection of time or MDM to be used to determine the E/M visit level and not use history and the physical exam to select the visit level.

CMS does not adopt CPT rule where a billable unit of time is considered to have been attained when the midpoint is passed (when time is used to select visit level for O/O E/M visits). CMS required the full time within the CPT code descriptors to be met in order to select an O/O E/M visit level using time. In addition, CMS is maintaining its payment policy that physicians and NPPs are not classified as having the same specialty and subspecialties. Their longstanding taxonomy for PFS services will continue to apply, where physicians and NPPs are not classified as having the same specialty, and the PFS does not recognize subspecialties.

CMS notes that the values it established for the revised O/O E/M codes were finalized in conjunction with a policy that would have provided separate payment for the add-on code G2211 (inherent complexity to E/M visits). CMS is concerned that many of the RUC-recommended values do not fully accounts for the complexity of certain visits, especially for those in the office setting, nor does the RUC-recommended values fully reflect appropriate relative values, since separate payment is not available for G2211. Section 113 of the Consolidated Appropriations Act delayed Medicare payment for G2211 until at least January 1, 2024.

Hospital Inpatient or Observation Care (CPT Codes 99218-99236)

Coding Changes and Visit Selection

Effective January 1, 2023, the CPT Editorial Panel deleted seven observation care codes and revised nine codes to create a single set of codes for inpatient and observation care. The code descriptors were also changed to allow level of service to be based on total time or MDM, as well as updating documentation requirements. Three initial observation care codes (99218-99220) and three subsequent observation care codes (99224-99226) were deleted. Six hospital inpatient care codes were revised to allow these codes to be reported for hospital inpatient or observation care services and allow the codes to be selected by the billing practitioner based on either MDM or time.

In addition, the CPT Editorial Panel changed the name of the “Hospital Inpatient Care” code family to “Hospital and Observation Care”. The new code family includes three initial hospital or observation care codes (99221-99223) and three subsequent inpatient or observation care codes (99231-99233). The Panel also revised the three codes (99234-99236) under “Observation or Inpatient Care Services (including Admission and Discharge)”.

For codes 99221-99223 and 99231-99236, CMS finalized its proposal to adopt these revised CPT codes. CMS finalized that when a physician or practitioner selects these codes based on time, the number of minutes specified in the descriptor must be “met or exceeded.” CMS finalized its proposal to adopt the 2023 CPT Codebook instruction that “per day,” also referred to as “date of encounter,” means the “calendar date.”

CMS also finalized its proposal to adopt the 2023 CPT Codebook instruction that when using MDM or time for code selection, a continuous service that spans the transition of 2 calendar dates is a single service and is reported on one date, which is the date the encounter begins. If the service is continuous before and through midnight, all the time may be applied to the reported date of the service, that is, the calendar date the encounter began.

Finally, CMS finalized its proposal to retain its policy that a billing practitioner shall bill only one of the hospital inpatient or observation care codes for an initial visit, a subsequent visit, or inpatient or observation care (including admission and discharge), as appropriate, once per calendar date. CMS notes a medically appropriate history and/or examination is required but will no longer be used to select a visit level. In addition, CMS reminds practitioners working in hospitals that documentation needs to meet requirements for all payment systems and the Conditions of Participation.

“8 to 24 Hour Rule”

The “8 to 24-hour rule” policy was designed to avoid unintended incentives to keep a patient in the hospital past midnight during a stay lasting less than 24 hours. CMS finalized its proposal to retain the “8 to 24-hour rule” regarding payment of discharge CPT codes 99238 (Hospital inpatient or observation care; 30 minutes or less) and 99239 (more than 30 minutes) as follows:

- When a patient receives hospital inpatient or observation care for less than 8 hours, only the Initial Hospital Inpatient or Observation Care (CPT codes 99221 – 99223) shall be reported by the practitioner for the date of admission. Hospital or Observation Discharge Day Management (CPT codes 99238-99239) shall not be reported for this scenario.
- When a patient is admitted for hospital inpatient or observation care and then is discharged on a different calendar date, the practitioner shall report Initial Hospital Inpatient or Observation Care (CPT codes 99221 – 99223) and Hospital Inpatient or Observation Discharge Day Management (CPT code 99238 or 99239).
- When a patient receives hospital inpatient or observation care for a minimum of 8 hours and is discharged on the same calendar date (thus the stay is less than 24 hours), Observation or Inpatient Care Services (Including Admission and Discharge Services) from CPT code range 99234 – 99236 shall be reported. CPT codes 99238-99239 cannot also be reported for this scenario.

This final policy is summarized in TABLE 22, reproduced below

Hospital Length of Stay	Discharged On	Code(s) to Bill
< 8 hours	Same calendar date as admission or start of observation	Initial hospital services only*
8 or more hours	Same calendar date as admission or start of observation	Same-day admission/discharge*
< 8 hours	Different calendar date than admission or start of observation	Initial hospital services only*
8 or more hours	Different calendar date than admission or start of observation	Initial hospital services* + discharge day management

*Plus prolonged inpatient/observation services, if applicable.

Definition of Initial and Subsequent Hospital Inpatient or Observation Visit

According to the 2023 CPT Codebook, pg. 15, an “initial” service may be reported when “the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. When advanced practice nurses and physician assistants are working with physicians they are in the exact same specialty and subspecialty as the physician” and “subsequent” service is reported when the patient has received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice during the stay. CMS does not recognize subspecialties, CMS proposes slightly amended definitions of “initial” and “subsequent” service:

- An initial service would be defined as one that occurs when the patient has not received any professional services from the physician or other qualified health care professional or

another physician or other qualified health care professional of the same specialty who belongs to the same group practice during the stay.

- A subsequent service would be defined as one that occurs when the patient has received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty who belongs to the same group practice during the stay.

CMS finalized their definition of initial and subsequent visits as proposed.

Transitions Between Settings of Care and Multiple Same-Day Visits for Hospital Patients Furnished by a Single Practitioner

CMS finalized the following policies as proposed:

- For the purposes of reporting an initial hospital inpatient or observation care service, a transition from observation status to inpatient status does not constitute a new stay.
- If a patient is seen in an office setting on one date and receives care at a hospital (for inpatient or observation care) on the next date from the same practitioner, both visits are payable to that practitioner, even if less than 24 hours has elapsed between the office visit and the hospital inpatient or observation care.
- When a patient is admitted to outpatient observation or as a hospital inpatient via another site of service (such as, hospital ED, office setting, nursing facility), all services provided by the practitioner in conjunction with that admission are considered part of the initial hospital inpatient or observation care when performed *on the same date as the admission*. Prolonged time can be counted toward reporting of prolonged inpatient/observation services (see Table 24).
- A practitioner may bill only for an initial hospital or observation care service if the practitioner sees a patient in the ED and decides to either place the patient in observation status or admit the patient as a hospital inpatient.
- If the inpatient care is being billed by the hospital as inpatient hospital care, the hospital care codes (CPT codes 99221 through 99223 and 99231 through 99239) apply. If the inpatient care is being billed by the hospital as nursing facility care, then the nursing facility care, then the nursing facility codes (CPT codes 99304 through 99316) apply.

Impact of Changes to Hospital Inpatient or Observation Codes on Billing and Claims Processing Policies

CMS finalized its proposal that starting in 2023, hospital inpatient and observation care by physicians will be billed using the same CPT codes (99221 through 99223, 99231 through 99233, and 99238 and 99239).

Prolonged Services for Hospital Inpatient or Observation Care

Effective January 1, 2023, codes 99356 and 99357 for prolonged service in the inpatient or observation setting will be deleted and replaced with code 99418 (*Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected*

using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)).

The 2023 CPT Codebook states, “Code 99418 is used to report prolonged total time (that is, combined time with and without direct patient contact) provided by the physician or other qualified health care professional on the date of an inpatient service (that is, 99223, 99233, 99236, 99255, 99306, 99310). Prolonged total time is time that is 15 minutes beyond the time required to report the highest-level primary service.”

CMS finalized its proposal not to adopt CPT code 99418 and finalized a single G code, G0316 (*Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report G0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99415, 99416, 99418). (Do not report G0316 for any time unit less than 15 minutes).*

CMS believes that the billing instructions for CPT code 99418 will lead to administrative complexity, potentially duplicative payments, and limit the ability to determine how much time was spent with the patient using claims data.

Code G0316 can only be applied to the highest-level hospital inpatient or observation care visit codes (CPT codes 99223, 99233, and 99236), and can only be used when selecting the E/M visit level based on time. A prolonged code would only be applied once the greatest amount of time for initial, subsequent, or same-day discharge visits has been exceeded.

This policy mirrors the policy the CPT Editorial Panel will apply to CPT code 99418 (although CMS disagrees with the CPT instructions regarding the point in time at which the prolonged code should apply). CMS does not believe that the CPT instructions for CPT code 99418 align with its payment policy and believes that a prolonged code is only applicable after both the total time described in the base E/M code descriptor is complete and the full 15-minutes described by the prolonged code are complete as well. Code G0316 can begin 15 minutes after the total times (as established in the Physician Time File) for CPT codes 99223, 99233, and 99236 have been met. Additionally, prolonged code G0316 would be for a 15-minute increment, and the entire 15-minute increment must be completed in order to bill G0316. CMS finalized its proposal to round the time when the prolonged service period begins to the nearest 5 minutes. CMS provides examples of correct billing in the final rule (see pages 601 and 602).

Valuation of Hospital Inpatient or Observation Care Services

CMS finalized its proposal to accept the below RUC recommendations for work RVUs for these codes. There are no PE inputs for these codes.

Valuation of Hospital Inpatient or Observation Care Services

CPT Code	Work RVUs	Intraservice Time	Total Time
99221	1.63	40 minutes	40 minutes
99222	2.6	55 minutes	55 minutes
99223	3.5	74 minutes	74 minutes
99231	1	25 minutes	25 minutes
99232	1.59	36 minutes	36 minutes
99233	2.4	52 minutes	52 minutes
99234	2	45 minutes	50 minutes
99235	3.24	68 minutes	76 minutes
99236	4.3	85 minutes	97 minutes

Hospital or Observation Discharge Day Management (CPT codes 99217, 99238, and 99239)

Coding Changes to Hospital Inpatient or Observation Discharge Day Management Services
Effective January 1, 2023, the CPT Editorial Panel deleted code 99217 for observation care discharge and revised the two codes 99238 and 99239 for hospital discharge day management. CMS finalized adopting revised codes 99238 and 99239 and other additional policies as proposed with the following clarifications:

- Only one claim for CPT code 99238 or 99239 may be submitted per patient, per hospital stay. The claim is submitted by the attending practitioner who is responsible for the discharge service. In the case of the death of the patient, CPT codes 99238 and 99239 are billed by the practitioner who personally performs the death pronouncement.
- The same practitioner may not bill both a hospital discharge CPT code 99238 or 99239 and a subsequent visit CPT codes 99231 through 99233 for the same patient on the same day.

Prolonged Services and Hospital Inpatient or Observation Discharge Day Management
Effective January 1, 2023, the CPT Editorial Panel deleted CPT codes 99356 and 99357 for Prolonged service in the inpatient or observation setting and replaced them with CPT code 99418 for prolonged inpatient or observation evaluation and management service(s).

CMS finalized its proposal that a practitioner is not able to bill prolonged services for hospital discharge; CPT codes 99418, 99358, 99359 and the G0316 code are not payable with the discharge management codes 99238 or 99239.

Valuation of Hospital Inpatient or Observation Discharge Day Management

CMS finalized its proposal to accept the RUC-recommended work RVU for codes 99238 (work RVU 1.50, intraservice time 28 minutes, total time 38 minutes); and 99239 (work RVU 2.15, intraservice time 45 minutes, 64 minutes total time).

Emergency Department Visits (CPT Codes 99281-99285)

Coding

Effective January 1, 2023, five ED visit codes to align with the principles included in the E/M office visit services by documenting and selecting level of service based on medical decision making. Code 99281 was revised such that the code may not require the presence of a physician or other qualified health care professional. Code 99282 descriptor was revised from “low” to “straightforward” complexity. Code 99283 descriptor was revised from “moderate” to “low” complexity. CMS finalized its proposal to adopt these revisions.

Sites of Service and Multiple Same-Day E/M Visits for ED Patients

The CPT Editorial Panel has revised CPT codes 99221 through 99223 to include both inpatient hospital and observation care services. CMS finalized its proposal that if a physician advises their patient to go to a hospital ED for inpatient care or observation and the physician is asked by the ED physician to come to the hospital to evaluate the patient, the physicians should bill as follows:

- If the patient is admitted to the hospital or placed in observation status by the patient’s personal physician, then this physician should bill only the appropriate level of the initial hospital inpatient or observation care (99221-99223), because all of the services provided by that physician in conjunction with the admission are considered part of the initial hospital inpatient or observation care when performed on the same date as the admission. The ED physician should bill the appropriate ED code.
- If the ED patient, based on the advice of the patient’s physician who also saw the patient in the ED, sends the patient home, the ED physician should bill the appropriate ED code. The patient’s physician should also bill the appropriate ED code. If the patient’s physician only advises by telephone, the physician cannot bill the ED code.

Similarly, if the ED physician requests that another physician evaluates a patient, the other physician should bill an ED visit code. If the patient is admitted by the second physician performing the evaluation, that physician shall bill an initial hospital inpatient or observation care code (CPT codes 99221 through 99223, as appropriate), and not an ED visit code.

CMS policy (Medicare Claims Processing Manual, IOM 100-04, Chapter 12, 30.6.12.6) includes that critical care and ED visits may be billed on the same day if performed by the same physician, or by physicians in the same group and specialty if there is documentation that the E/M service was provided prior to the critical care service at a time when the patient did not require critical care, that the service is medically necessary, and that the service is separate and distinct, with no duplicative elements from the critical care service provided later in the day, and that practitioners may bill for both services.

Valuation

CMS finalized its proposal to work RVUs and direct PE inputs for all five codes in the Emergency Department Visits as proposed. CMS finalized a work RVU of 0.25 for CPT code

99281, a work RVU of 0.93 for CPT code 99282, a work RVU of 1.60 for CPT code 99283, a work RVU of 2.74 for CPT code 99284 and a work RVU of 4.00 for CPT code 99285.

Prolonged Services

CMS finalized its proposal that the prolonged services described by HCPCS codes G0316, G0317, and G0318 would not be reportable in conjunction with ED visit codes, because the ED visit codes are not reported based on the amount of time spent with the patient.

Nursing Facility Visits (CPT Codes 99304-99318)

Coding Overview

Effective on January 1, 2023, the CPT Editorial Panel deleted code 99318, annual nursing facility (NF) assessment code, and revised the remaining nursing facility codes (initial and subsequent daily visits and nursing facility discharge day management) to better align with the principles included in the E/M office visit services by documenting and selecting level of service based on total time or MDM.

CMS finalized its proposal that when total time on the date of encounter is used to select the appropriate level of a nursing facility visit service code, both the face-to-face and non-face-to-face time personally spent by the physician (or other qualified health care professional that is reporting the office visit) assessing and managing the patient are summed to select the appropriate code to bill.

CMS finalized adopting the 2023 CPT Codebook guidance for reporting initial nursing facility care, including that transitions between skilled nursing facility level of care and nursing facility level of care do not constitute a new stay.

CMS finalized its proposal to adopt a number of billing policies:

- The initial comprehensive assessment required under 42 CFR 483.30(c)(4) will be billed as an initial NF visit (CPT code 99304-99306). A practitioner may bill the most appropriate initial nursing facility care code (CPT codes 99304 -99306) or subsequent nursing facility care code (CPT codes 99307 -99310), if the practitioner furnishes services that meet the code descriptor requirements, even if the service is furnished prior to the required initial comprehensive assessment.
- A given practitioner cannot bill an initial NF visit and another E/M visit (such as an O/O visit or ED visit) on the same date of service, for the same patient. However, the time the practitioner spends furnishing a visit in another setting can be counted toward reporting prolonged NF services, if requirements for reporting prolonged NF services are met.
- CMS is adopting the CPT instruction for reporting initial nursing facility care, which provides that transitions between SNF level of care and nursing facility level of care do not constitute a new stay.
- An initial service is one that occurs when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty who

belongs to the same group during the stay. A subsequent service is one that occurs when the patient has received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the exact same specialty who belongs to the same group during the stay.

Valuation

CMS finalized its proposal to adopt the RUC-recommended work RVUs for all of the nursing facility codes (99304-99310) and RUC-recommended direct PE inputs for all the codes in the family (99305- 99310). CMS will also adopt the CPT codes as revised.

Prolonged Services

CMS finalized its proposal prolonged nursing facility services by a physician or NPP would be reportable using prolonged service HCPCS code G0317, which would be used to account for additional time spent when the total time for the NF service is exceeded by 15 or more minutes. Without any frequency limitation, physicians and NPPs would be able to bill G0317 for each additional 15-minute increment of time beyond the total time for CPT codes 99306 and 99310.

CMS finalized its proposal that the practitioner would include any prolonged service time spent within the surveyed timeframe, which includes the day before the visit, the day of the visit, and up to and including 3 days after the visit.

HCPCS code G0317 includes time without direct patient contact. There would no longer be a need to use CPT codes 99358 and 99359 (prolonged E/M service on a date other than the face-to-face E/M) in conjunction with NF visits. CMS finalized its proposal to change the payment status for CPT codes 99358 and 99359 to “I” (*Not valid for Medicare purposes*). Additional information on these codes can be found on the PFS Care Management website at <https://www.cms.gov/Medicare/Medicare-Fee-for-ServicePayment/PhysicianFeeSched/Care-Management>.

Nursing Facility Discharge Management (CPT Codes 99315-99316)

Coding

Codes 99315 and 99316 (Nursing facility discharge day management) are used to report the total duration of time spent by a physician or other qualified health care professional for the final nursing facility discharge of a patient, including final examination of the patient and discussion of the NF stay. These services require a face-to-face encounter, which may be performed on a calendar date prior to the actual discharge date. The time of the face-to-face encounter performed on a date prior to the discharge date is counted toward codes 99315 and 99316 and is not separately reportable.

CMS finalized its proposal that a physician or qualified NPP may report CPT codes 99315 or 99316 for a patient who has expired only if the physician or qualified NPP personally performed the death pronouncement.

Valuation

CMS finalized its proposal to accept the RUC-recommended work RVU of 1.50 for code 99315 and work RVU of 2.50 for code 99316. CMS also finalized its proposal to accept the RUC-recommended direct PE inputs for CPT codes 99315 and 99316.

Prolonged Services

CMS finalized its proposal that prolonged services would not be reported with nursing facility discharge management codes since time on any day can be included when billing CPT code 99315 or 99316 with no ceiling time.

Annual Nursing Facility Assessment (CPT Code 99318)

Coding

Effective 2023, code 99318 (*Evaluation and management of a patient involving an annual nursing facility assessment*) will be deleted and seven nursing facility codes will be revised to align with the principles included in the O/O E/M visits by documenting and selecting level of service based on total time or MDM. CMS finalized its proposal to accept the deletion of code 99318. Instead of code 99318, codes 99308, 99309, 99310 could be used to report the required annual visit.

Valuation

Given the deletion of code 99318, the RUC recommends that 10 percent of the CPT code 99318 utilization would go to code 99308, with a work RVU of 1.16; 85 percent of the utilization would go to code 99309, with a work RVU of 1.55; and 5 percent of the utilization would go to code 99310, with a work RVU of 2.35. CMS finalized its proposal to accept the RUC-recommended utilization estimates.

Home or Residence Services (CPT Codes 99341, 99342, 99344, 99345, 99347-99350)

Coding

Effective 2023, Home or Residence Services codes (99341, 99342, 99344, 99345, 99347-99350) were revised to align with the principles of the O/O E/M visit codes by allowing physicians and NPPs to document and select the level of service based on total practitioner time or MDM level. The home and domiciliary E/M code family will be revised by the CPT to include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance abuse treatment facilities, and a patient's home. CMS finalized its proposal to adopt the CPT codes as revised for reporting these services.

Valuation

CMS finalized its proposal to adopt the RUC-recommended work RVU for all eight CPT codes (99341, 99342, 99344, 99345, 99347-99350). CMS finalized the RUC-recommended direct PE inputs for CPT codes 99345, and 99347-99350. For codes 99341 and 99342, CMS is refining the direct PE inputs by removing supply item SK062 (patient education booklet). For CPT code 99344, CMS is refining the direct PE inputs by removing supply items SK062 (patient education

booklet), SJ053 (swab-pad, alcohol), and SJ061 (tongue depressor). Since codes 99341, 99342, and 99344 would typically have other procedures performed on the same date, these supplies would be duplicative.

Prolonged Services for Home or Residence Services

CMS finalized its proposal that prolonged home or residence services by a physician or NPP would be reportable using HCPCS code G0318. This code would be reportable when the total time for the home or residence visit is exceeded by 15 or more minutes. It would be reportable as an add-on code to CPT codes 99345 or 99350 once the practitioner spends 15+ minutes beyond the total time finalized for the primary service.

CMS allows the physician or NPP to include any prolonged service time spent within the surveyed timeframe for the home or residence services code family, which includes pre-service time 3 days before the date of encounter, intraservice time on the date of encounter, and post-service time that includes 7 days after the date of encounter. For code 99345, report prolonged services once 141 or more minutes are spent by a physician or NPP providing home or residence services. For code 99350, prolonged services would be reportable once 112 or more minutes are spent by a physician or NPP providing home or residence services.

CMS finalized its proposal to change the status indicator for codes 99358 and 99359 to “I,” (not valid for Medicare purposes since prolonged services with or without direct patient contact would be reportable under G0318).

Cognitive Assessment and Care Planning (CPT Code 99483)

Coding and Valuation

Effective 2023, the CPT Editorial Panel revised CPT code 99483 to replace “50 minutes” with “60 minutes”. CMS does not accept the RUC-recommended work RVU of 3.50 and finalized its proposal to increase it from the current 3.80 to 3.84 to account for the increase in physician time. CMS finalized the RUC-recommended PE inputs.

Prolonged Services

CMS finalized that code 99483 can be billed with HCPCS code G2212 (prolonged office/outpatient E/M services) when 15 or more minutes beyond the total time is spent by the physician or NPP. Time that is spent by the physician or NPP on any date within the surveyed timeframe for CPT code 99483 (within 3 days prior or 7 days after the date of the in-person visit) may be counted toward the reporting of prolonged services. CMS is revising the long descriptor for G2212 to include reference to CPT code 99483 as a code that can be listed separately with G2212.

Prolonged Services

CMS finalized its proposal to create three G codes (G0316, G0317 and G0318) for reporting of prolonged Other E/M services (one for each Other E/M family for which prolonged services

would apply, namely inpatient/observation visits, nursing facility visits, and home or residence visits).

The AMA disagreed with the CMS and stated it is important that physicians have one set of clear codes and guidelines to report prolonged services. The AMA prefers CMS to rely on CPT codes and guidelines. The AMA agreed with CMS' concerns that potential overlap should be eliminated and requested that if the CPT Editorial Board consider revisions to these codes that CMS be an active participant in the public and open CPT process.

Prolonged Services Valuation

Prolonged Services with Direct Patient Contact (CPT Codes 99354-99357)

Effective 2023, codes 99354-99357 will be deleted. CMS finalized its proposal to accept this deletion.

Prolonged Services on a Different Date than the E/M (CPT Codes 99358-99359)

CMS finalized its proposal to assign an inactive status "I" to these codes.

Prolonged Services Clinical Staff Services (CPT codes 99415 and 99416)

CPT code 99415 is reported for the first hour of prolonged clinical staff services provided in addition to an office E/M visit. Code 99416 is reported for each additional 30 minutes beyond that first hour of prolonged clinical staff service time that was provided in addition to the O/O E/M visit. CMS finalized its proposal to accept the RUC recommended direct PE inputs.

Valuation of Prolonged Other E/M Services (HCPCS Codes G0316, G0317 and G0318)

CMS does not agree that there is inherently greater complexity of patient need or intensity of work for E/M visits furnished in non-office settings compared to the office settings. CMS believes it would be more accurate to make payment based on the same time increment of physician work in these various settings. CMS finalized its proposal that the three prolonged visit HCPCS G codes G0316-G0318 be valued identically across settings, based on the RUC recommended value work RVU of 0.61 for these codes with a crosswalk to CPT code 99417. CMS will continue to use HCPCS code G2212 rather than code 99417.

Consultations (Codes 99241-99255)

CMS stopped recognizing consult codes in 2010. CMS did not review the RUC recommendations for consultation codes.

Payment for Multiple Same-Day Visits

CMS finalized its proposal to continue its longstanding policies when more than one Other E/M visit can be billed by the same practitioner for the same patient on the same date of service, particularly when a patient is being transferred among multiple care settings.

Split (or Shared) Services

CMS finalized its proposal to delay implementation of its definition of the substantive portion as more than half of the total time until January 1, 2024. A split (or shared) visit is an E/M visit performed by both a physician and an NPP in the same group practice. CMS policy states that for split (or shared) visits in the facility (e.g., hospital) setting, the physician can bill for the services if they perform a substantive portion of the encounter. Delaying implementation would allow for the changes in the coding and payment policies for Other E/M visits to take effect for 2023. The delay allows another opportunity for interest parties to provide comment and feedback. In addition, the delay allows for a one-year transition for providers to get accustomed to the new changes and adopt their workflow in practice.

With this delay, CMS finalized its proposal to amend its regulations for visits other than critical care visits furnished in calendar year 2022 and 2023, substantive portion means one of the three key components (history, exam or MDM) or more than half of the total time spent by the physician and NPP performing the split (or shared) visit.

Technical Correction to the Conditions for Payment: Split (or Shared) Visits

CMS discovered typographical error in the instructions in the 2022 PFS final rule (86 FR 64996). CMS finalized its proposal to amend part 415 subpart D by removing the regulation at § 415.140 and relocating that section to subpart C.

Technical Correction for Split (or Shared) Critical Care Services

In the 2022 PFS final rule, at 86 FR 65162, CMS stated in error, “Similar to our proposal for split (or shared) prolonged visits, the billing practitioner would first report CPT code 99291 and, if 75 or more cumulative total minutes were spent providing critical care, the billing practitioner could report one or more units of CPT code 99292.” CMS intended to state that CPT code 99292 could be billed after 104, not 75, or more cumulative total minutes were spent providing critical care. CMS stated that its policy is the same for critical care whether the patient is receiving care from one physician, multiple practitioners in the same group and specialty who are providing concurrent care, or physicians and NPPs who are billing critical care as a split (or shared) visit.

Determination of Malpractice RVUs (Page 644)

Malpractice (MP) RVUs are comprised of three factors (1) specialty-level risk factors derived from data on specialty-specific malpractice premiums incurred by practitioners; (2) service-level risk factors derived from Medicare claims data of the weighted average risk factors of the specialties that furnish each service; and (3) an intensity/complexity service adjustment to the service level risk factor based on either the higher of the work RVU or clinical labor portion of the direct PE RVU. MP RVUs are updated annually to reflect changes in the mix of practitioners for the services, and to adjust MP RVUs for risk for intensity and complexity. The specialty mix assignments are also now based on three years of data instead of only one year of data. In 2020,

CMS finalized a policy to review and update the MP RVUs every three years, consistent with its review of the Geographic Practice Cost Indices (GPCIs).

CMS finalized its proposal to use updated MP premium data from State insurance rate filings to calculate CY 2023 MP RVUs. It also finalized two methodological refinements to the calculation process. First, for specialties with incomplete premium data, CMS used mapped data from a more commonly reported specialty within the same risk class instead of excluding the underrepresented data. Secondly, CMS used a true MP risk index (ratio of a specialty's national average premium to the volume-weighted national average premium across all specialties) instead of derived risk factors (ratio of a specialty's national average premium to a single referent specialty's national average premium) in the calculation of MP RVUs.

The ACR alerted CMS to a technical error in its ratesetting system that resulted in low MP RVUs for the professional component of imaging services relative to the TC services. CMS corrected the technical error in the final rule, resulting in higher MP RVUs for the PC of many imaging services.

Rebasing and Revising the Medicare Economic Index (Page 808)

The proposed rule included proposals to rebase and revise the Medicare Economic Index (MEI) to reflect current market conditions. The current MEI is based on 2006 data collected by the AMA's Physician Practice Information Survey (PPIS). This survey produced flawed data for radiology and negatively impacted imaging reimbursement. MEI cost weights have been used to update Geographic Practice Cost Index (GPCI) cost share weights to weigh the four components of the practice expense GPCI (employee compensation, office rent, purchased services and medical equipment, supplies and miscellaneous items). It is also used to recalibrate the relativity adjustment to ensure that the total pool of aggregate PE RVUs remains relative to the pool of work and MP RVUs. The most recent recalibration was done for the 2014 RVUs, when the MEI was last updated.

CMS finalized its proposal to delay the implementation of the proposed rebased and revised MEI cost weights for both 2023 rate setting and GPCIs in order to allow stakeholders the opportunity to review and comment on the proposals. CMS finalized its proposal to rebase and revise the MEI based on a methodology that uses publicly available data sources for input costs that represent all types of physician practice ownership; that is, not limited to only self-employed physicians.

In response to comments received, CMS is revising the methodology for estimating the 2017 expenses for physician net income, correcting the allocation of registered nurse (RN) compensation costs from physician compensation to clinical, nonphysician compensation, and adjusting the shares for allocating the U.S. Census Bureau's Services Annual Survey (SAS) compensation costs between physician and non-physicians by factoring in differences in average weekly hours by occupation.

Table 158 in the final rule provides estimated impacts of the proposed rebased and revised MEI cost share weights by specialty, including the year 1 impact of a transition approach and the combined impact of the full update. The impacts vary widely by specialty and negatively impact facility fees far more than non-facility. For the combined impact of the full MEI changes, diagnostic radiology estimates are a negative 1 percent change for non-facility and negative 8 percent for facility, interventional radiology impacts are estimated at positive 5 percent for non-facility and negative 9 percent for facility, nuclear medicine neutral 0 percent impact for non-facility and negative 4 percent for facility and radiation oncology positive 6 percent impact for non-facility and negative 8 percent for facility.

The ACR will continue to work with its consultants to decipher the details of these policies and their impacts on radiology.

Payment for Medicare Telehealth Services (page 115)

In the 2003 PFS final rule, CMS established a process for adding or deleting services from the Medicare telehealth list. CMS assigns requests to two categories: Category 1 and Category 2. Category 1 services are similar to services that are currently on the telehealth list. Category 2 services are not similar to services on the telehealth list, and CMS requires evidence demonstrating the service furnished by telehealth improves the diagnosis or treatment of an illness or injury or improves the functioning of a malformed body part. In the 2021 PFS final rule, CMS created a third category for the Medicare telehealth list, Category 3. This new category describes services that added to the telehealth services list during the PHE for which there is likely to be clinical benefit when furnished via telehealth, but there is not sufficient evidence available to consider adding the services under the Category 1 or Category 2 criteria.

Table 12 in the final rule lists the services that CMS finalized for addition to the Medicare Telehealth Services List on a Category 3 basis. Table 13 lists the services CMS finalized for permanent addition to the Medicare Telehealth Services List on a Category 1 basis.

Services Proposed for Removal from the Medicare Telehealth Services List After 151 Days Following the End of the PHE

For CY 2023, CMS finalized a number of policies related to Medicare telehealth services including making several services that are temporarily available as telehealth services for 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 finalized a policy to implement the telehealth provisions in the CAA, 2022 via program instruction or other subregulatory guidance. These policies extend certain flexibilities in place during the PHE for 151 days after the PHE ends. Table 14 lists the services to be removed from the Medicare Telehealth Services List After 151 Days following end of the PHE.

Other Non-Face-to-Face Services Involving Communications Technology under the PFS

Under Medicare Part B, certain types of services, including diagnostic tests, services incident to physicians' or practitioners' professional services, and other services, are required to be furnished under specific minimum levels of supervision by a physician or practitioner. CMS did not propose to make the temporary exception to allow immediate availability for direct supervision through virtual presence permanent. CMS requested information on whether the flexibility to meet the immediate availability requirement for direct supervision through the use of real-time, audio/video technology should potentially be made permanent. CMS expects to continue to permit direct supervision through virtual presence through at least the end of CY 2023 under their previously finalized policy which, as specified in § 410.32(a)(3)(ii), continues through the end of the calendar year in which the PHE ends.

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers (Page 1027)

This section of the rule begins by acknowledging that existing statute and regulations for colorectal cancer (CRC) screening expressly give the Secretary authority to add other tests and procedures for colorectal cancer screening “based on consultation with appropriate organizations”. CMS finalized its proposal to expand coverage of certain CRC screening tests by updating the minimum age to 45 years in accordance with the most recent United States Preventive Services Task Force (USPSTF) guidelines. CMS also finalized its proposal to expand the definition of screening to include a follow-on screening colonoscopy after a positive result on a non-invasive stool-based CRC screening test. This means that the colonoscopy will be paid at 100% without patient cost sharing.

Background

CMS stated in the proposed rule that in calendar year 2019, CRC had the 4th highest rate of new cancer cases and the 4th highest rate of cancer deaths in the United States. The agency quotes the Center for Disease Control and Prevention (CDC) stating, “Colorectal cancer almost always develops from precancerous polyps (abnormal growths) in the colon or rectum. Screening tests can find precancerous polyps, so that they can be removed before they turn into cancer...”. Rural and minority communities have a higher incidence of CRC. The 2021 USPSTF recommendation indicates that evidence shows disparities in the African American population are primarily due to inequities in access to and utilization of CRC screening and not genetic differences.

The National Colorectal Cancer Roundtable recommends that a patient should only be counted as having completed the CRC screening process after a colonoscopy is performed if there is a positive result on an initial non-invasive test. Under current Medicare policy, a subsequent colonoscopy is considered diagnostic and as such, is subject to patient cost sharing.

Statutory Authority

Section 1861(pp) of the Act defines “colorectal cancer screening tests” as one of the following:

- Screening fecal-occult blood test;

- Screening flexible sigmoidoscopy; and
- Screening colonoscopy.

Section 1861(pp)(1)(D) of the Act authorizes the Secretary to expand the definition of CRC screening test to other tests or procedures and modifications to the tests and procedures as the Secretary determines appropriate, in consultation with appropriate organizations. In addition, Section 1834(n) of the Act, added by section 4105 of the Affordable Care Act, grants the Secretary the authority to modify coverage of certain preventive services consistent with the recommendations of the USPSTF.

Regulatory Authority

Implementing regulations for CRC are codified at §410.37.

National Coverage Determination

NCD 210.3 CRC Screening Tests was last revised effective January 19, 2021, expanding coverage to include Blood-based Biomarker Tests. Cologuard™ Multi-target Stool DNA Testing was added to the NCD in 2014. The 2021 revision did not lower the screening age to 45 because the USPSTF recommendations had not yet been finalized.

Revisions

CMS finalized its proposal to exercise its authority under section 1834(n) of the Act to modify coverage of certain CRC screening tests to begin when the individual is age 45 or older. This includes the tests included in the May 2021 USPSTF revised recommendation, including stool-based tests of gFOBT, iFOBT and sDNA, and direct visualization test of flexible sigmoidoscopy. Screening colonoscopy does not have a minimum age requirement under Medicare coverage.

CMS also finalized its proposal to begin coverage of barium enema and blood-based biomarker tests at age 45. These tests were not recommended in the earlier mentioned May 2021 revised USPSTF recommendation, but they are Medicare covered CRC screening tests and CMS believes important alternatives to the stool based and direct visualization tests, especially for individuals with medical complexity and those in rural and underserved communities. The policy reflects CMS's belief that consistent coverage and payment policies will be important in promoting CRC screening, which will result in expanded prevention, early detection and improved health outcomes.

CMS did not propose to modify existing conditions of coverage or payment for maximum age limitations and frequency limitations.

CMS consulted with and reviewed recommendations from the American Cancer Society, the American Society of Colon and Rectal Surgeons, the U.S. Multi-Society Task Force on Colorectal Cancer and the CDC.

The rule also discusses situations where the follow-on screening colonoscopy requires additional procedures furnished in the same clinical encounter such as polyp removal. In this scenario, the

phased-in Medicare payment percentages for colorectal cancer screening services described in regulation at § 410.152(l) and finalized in the CY 2022 PFS final rule (86 FR 65177 through 65179) will apply. When the follow-on screening colonoscopy includes the removal of tissue or other related services during the same clinical encounter, the beneficiary coinsurance will be reduced over time from 15 percent for services furnished during CY 2023 through CY 2026 to 10 percent for services furnished during CY 2027 through 2029 to zero percent beginning in CY 2030 and thereafter.

CMS notes at the end of this section of the rule, “The scope of our proposals is limited to CRC screening tests and do not address the coverage or payment status of other screening services or tests recommended by the USPSTF or covered by Medicare.”.

The ACR submitted extensive comments to CMS requesting that CT colonography be included as a covered option for colorectal cancer screening. It is currently the only USPSTF and ACS approved test that is not covered by Medicare. CMS responded that they believe these comments were outside the scope of this rule and will take them into consideration for possible future rulemaking.

Medicare Shared Savings Program (MSSP) (page 1083)

The Affordable Care Act established the Medicare Shared Savings Program (MSSP) to facilitate coordination and cooperation among healthcare providers to improve quality of care for Medicare fee-for-service (FFS) beneficiaries and reduce Medicare expenditures. CMS continues to take important steps toward their 2030 goal of having 100% of traditional Medicare beneficiaries in an accountable care relationship with their healthcare provider by 2030. As of January 1, 2022, over 11 million people with Medicare receive care from one of the 528,966 health care providers in the 483 accountable care organizations (ACOs) participating in the MSSP. Eligible groups of providers and suppliers may participate in the MSSP by forming or participating in an Accountable Care Organization (ACO). Under the MSSP, participants in an ACO continue to receive traditional FFS payments under Parts A and B, but the ACO may be eligible to receive a shared savings payment if it meets specified quality and savings requirements. Many of the policies finalized help align policies under the MSSP and under the Innovation Center’s ACO models. CMS sought to make changes to the MSSP that would advance their overall value-based care strategy of growth, alignment, and equity.

CMS finalized many proposals with the aim of increasing health equity and aligning with other CMS programs. CMS will allow ACOs applying to the program that are inexperienced with performance-based risk to participate in one 5-year agreement under a one-sided shared savings model, to provide these ACOs more time to invest in infrastructure and redesigned care processes for high quality and efficient health care service delivery before transitioning to performance-based risk. These new policies would allow an organization new to the MSSP that is not renewing or reentering as an ACO and qualifies as low revenue can receive a one-time payment of \$250,000 and quarterly payments for the first two years of a five-year period.

CMS finalized adjustments to ACO benchmarks to promote long-term participation. CMS will also revise the benchmarking methodology to reduce the effect of ACO performance on ACO historical benchmarks. CMS finalized an extension of the incentive for reporting electronic Clinical Quality Measures (eCQMs)/MIPS Clinical Quality Measures (CQMs) through performance year 2024 to align with the sunseting of the CMS Web Interface reporting option.

Supplemental Payment for Indian Health Service and Tribal Hospitals and Hospitals located in Puerto Rico

CMS will exclude the new supplemental payment under the Medicare Hospital Inpatient Prospective Payment System (IPPS) for Indian Health Service (IHS)/Tribal hospitals and hospitals located in Puerto Rico from the determination of Medicare Parts A and B expenditures for purposes of calculations under the Shared Savings Program and include this new supplemental payment in calculations of ACO participant revenue for the performance year beginning January 1, 2023, and subsequent performance years.

Updates to the Quality Payment Program (QPP) (Page 1859)

Within the final rule, CMS limited updates to traditional MIPS and focuses on further refining the implementation of MIPS Value Pathways (MVPs), responded to public feedback on digital quality measurement (dQM), and advancing health equity across CMS programs and policies. *Continuing to Advance to Digital Quality Measurement and the Use of Fast Healthcare Interoperability Resources (FHIR) in Physician Quality Programs—Request for Information* In the proposed rule, CMS provided information and sought comment on using electronic clinical quality measures (eCQMs) as the test cases for the digital quality measurement transition and informing on converting non-eCQM existing measures into dQMs, the department of Health and Human Services (HHS) interoperability infrastructure, dQM's role in learning health systems (LHS), ONC's rules supporting CMS' transition to dQM, and other federal agency alignments. In the final rule, CMS thanked stakeholders for their input and noted their plan to utilize comments when moving forward with future dQM policies.

Transforming MIPS: MVP Strategy

CMS anticipates that the more clinicians participate in MVPs, the more robust the data for informing and improving clinical practice, including advancing programmatic policies supporting health equity. In 2021 CMS released *Paving the Way to Equity: A Progress Report*, which describes CMS' Equity Plan for Medicare and progress between 2015 and 2021. The report also addresses emerging opportunities to augment CMS' current strategic initiatives to ensure health equity, like the 10-year approach for embedding it across CMS. For instance, MIPS proposed measures and activities have begun addressing social health determinants.

Though a deadline is not final for sunseting traditional MIPS, beginning in 2023, eligible clinicians may voluntarily participate in MVPs appropriate for their practice. CMS intends to ascertain individual and group (including subgroup) reporting characteristics during this early

MVP participation phase, emphasizing MVPs' influence on practices transitioning to alternative payment models (APMs).

CMS finalized its proposal to convene 30-day comment periods to collect public input on candidate and established MVPs. The comment periods will be separate from the rulemaking process. For candidate MVPs, CMS will collect public feedback and potentially revise MVPs before subjecting them to rulemaking. CMS will also solicit public comments on established MVPs during the MVP maintenance period. Should input from the 30-day comment period be appropriate to revise an MVP, CMS will host public listening sessions so that CMS may learn the public's opinion on the potential changes before proposing an updated dated MVP during rulemaking.

CMS finalized the following MVPs for the 2023 performance year: Advancing Cancer Care, Optimal Care for Kidney Health, Optimal Care for Patients with Episodic Neurological Conditions, Supportive Care for Neurodegenerative Conditions, and Promoting Wellness, in addition to updates on six of the seven previously established MVPs. Beginning in 2023, 12 MVPs will be available for voluntary reporting.

Multiple updates address subgroup reporting. Like limiting one subgroup per TIN-NPI combination, determining group specialty type(s) utilizing Medicare Part B claims data, preventing subgroups from gaming MVP cost and administrative claims data measures and scoring subgroups that do not report their MVP data.

MIPS Category Weighting

The category weights for the 2023 performance year are: **Quality – 30%, Cost – 30%, Promoting Interoperability (PI) – 25%, and Improvement Activities (IA) – 15%.** These are the same values finalized for the 2022 performance year and are unlikely to change in future years.

The proposed rule continues to offer category reweighting for physicians who are unable to submit data for one or more performance categories. In most cases, the weight of these categories will continue to be redistributed to the Quality category.

MIPS Performance Threshold and Incentive Payments

The MIPS performance threshold is the value which determines whether a MIPS participant will receive a positive, negative, or neutral payment adjustment during the associated MIPS payment year. During the first five years of MIPS, this threshold was set at a low value and incrementally increased each subsequent year to reduce burden on clinicians and ease them into the program. From 2022 onward, CMS is statutorily required to set the MIPS performance threshold at either a mean or median value based on previous years' scoring data. **For the 2023 performance year, CMS is setting a 75-point performance threshold, which represents the mean of 2019 performance year data.** This means that clinicians scoring 75 points or higher will receive a

neutral or positive payment adjustment, while clinicians falling below 75 points will receive a negative adjustment. **This is the same as the current 2022 performance threshold.**

CMS will also remove the exceptional performance bonus beginning in 2023. During previous years, scores that surpassed the exceptional performance threshold received additional funds from CMS. This was finalized for removal in the 2022 MPFS final rule. In previous rules, CMS finalized a maximum payment adjustment of +/- 9% for performance years 2020 and beyond. This will remain unchanged in 2023.

Low-Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations

CMS has not made any changes to the low-volume threshold criteria. To be excluded from MIPS in 2023, clinicians or groups must meet one of the following three criteria: have \leq \$90K in allowed charges for covered professional services, provide covered care to \leq 200 beneficiaries, or provide \leq 200 covered professional services under the Physician Fee Schedule. CMS will retain the established opt-in policy, allowing physicians who meet some but not all of the low-volume threshold criteria to participate in MIPS.

CMS is maintaining the six-point small practice bonus included in the Quality performance category score and continues to award small practices three points for submitted quality measures that do not meet case minimum requirements or lack a benchmark.

Quality Performance Category

CMS finalized their proposal to amend the definition of a “high priority measure” to include quality measures which pertain to health equity.

Consistent with the proposed rule, CMS has not finalized any major changes to the Quality category, however some changes which were finalized in 2022 will go into effect beginning with the 2023 performance year. In previous years, non-benchmarked measures which met data completeness were eligible to receive 3 points, with the possibility of a higher score if enough data was received to establish a same-year benchmark. Benchmarking measures were scored between three and ten points if meeting data completeness. **Beginning with performance year 2023, CMS will change the scoring range for benchmarked measures to 1 to 10 points, by removing the 3-point floor. CMS will also assign zero points to non-benchmarked measures that have been in the program for three or more years (excluding small practices, who will continue to receive three points).** New measures will continue to receive a minimum of seven points in their first year and five points in their second year.

Quality Measures Finalized for Addition and Removal

CMS has removed three measures historically available for reporting through ACR’s NRDR QCDR:

- #76: Prevention of Central Venous Catheter (CVC)-Related Bloodstream Infections

- #110: Preventive Care and Screening: Influenza Immunization
- #111: Pneumococcal Vaccination Status for Older Adults

Measures #110 and #111 have been combined into a new measure, #493: Adult Immunization Status, which includes immunization for influenza, tetanus and diphtheria, zoster and pneumococcal in its numerator.

CMS will add the following new measure to the Diagnostic Radiology and Radiation Oncology measure sets in 2023:

- #487: Screening for Social Drivers of Health
-

Additionally, CMS has finalized an updated version of measure #145: Exposure Dose Indices for Procedures Using Fluoroscopy in accordance with changes proposed by the ACR. To meet numerator performance for this measure, exposure dose indices (reference air kerma, kerma-area product, or peak skin dose) must be provided; exposure time and number of images would be insufficient.

Quality Data Completeness Requirements

CMS did not make any changes to the data completeness requirements for 2023; quality measure submission must continue to account for at least 70% of total exam volume. This number defines the minimum subset of patients within a measure denominator that must be reported. **However, CMS has finalized their proposal to increase this threshold to 75% for the 2024 and 2025 performance years.**

Cost Performance Category

CMS finalized their proposal to add the Medicare Spending Per Beneficiary (MSPB) Clinician measure as a care episode group. This measure accounts for the patient’s clinical diagnoses at the time of hospitalization and includes the costs of items and services provided during the episode of care.

The Cost category will remain weighted at 30% for 2023.

Improvement Activities Performance Category

CMS did not make any major changes to the Improvement Activities performance category. This category will remain weighted at 15% as in previous years. CMS has finalized the proposal to add 4 new activities and remove 6 previously adopted activities.

Several of the QCDR-related improvement activities have been removed as they were considered duplicative of one another. The “Use of QCDR data for ongoing practice assessment” activity (IA_PSPA_7) has been updated to comprise elements of the removed IAs. The new description of IA_PSPA_7 is as follows:

“Participation in a Qualified Clinical Data Registry (QCDR) and use of QCDR data for ongoing practice assessment and improvements in patient safety, including:

- Performance of activities that promote use of standard practices, tools, and processes for quality improvement (for example, documented preventive health efforts, like screening and vaccinations) that can be shared across MIPS eligible clinicians or groups);
- Use of standard questionnaires for assessing improvements in health disparities related to functional health status (for example, use of Seattle Angina Questionnaire, MD Anderson Symptom Inventory, and/or SF-12/VR-12 functional health status assessment);
- Use of standardized processes for screening for drivers of health, such as food security, housing stability, and transportation accessibility;
- Generation and use of regular feedback reports that summarize local practice patterns and treatment outcomes, including for populations that are disadvantaged and/or underserved by the healthcare system;
- Use of processes and tools that engage patients to improve adherence to treatment plans;
- Implementation of patient self-action plans;
- Implementation of shared clinical decision-making capabilities;
- Use of QCDR patient experience data to inform and advance improvements in beneficiary engagement;
- Promotion of collaborative learning network opportunities that are interactive;
- Use of supporting QCDR modules that can be incorporated into the certified EHR technology; OR
- Use of QCDR data for quality improvement, such as comparative analysis across specific patient populations of adverse outcomes after an outpatient surgical procedure and corrective steps to address these outcomes.”

Improvement Activities Finalized for Adoption

Improvement Activity Title	Description	Category Weight
Adopt Certified Health Information Technology for Security Tags for Electronic Health Record Data	Use security labeling services available in certified health Information Technology (IT) for electronic health record (EHR) data to facilitate data segmentation	Medium
Create and Implement a Plan to Improve Care for Lesbian, Gay, Bisexual, Transgender, and Queer Patients	Create and implement a plan to improve care for lesbian, gay, bisexual, transgender, and queer (LGBTQ+) patients by understanding and addressing health disparities for this population. The plan may include an analysis of sexual orientation and gender identity (SO/GI) data to identify disparities in care for LGBTQ+ patients. Actions to implement this activity may also include identifying focused goals for addressing disparities in care,	High

	collecting and using patients’ pronouns and chosen names, training clinicians and staff on SO/GI terminology (including as supported by certified health IT and the Office of the National Coordinator for Health Information Technology 2 US Core Data for Interoperability [USCDI]), identifying risk factors or behaviors specific to LGBTQ+ individuals, communicating SO/GI data security and privacy practices with patients, and/or utilizing anatomical inventories when documenting patient health histories.	
Create and Implement a Language Access Plan	Create and implement a language access plan to address communication barriers for individuals with limited English proficiency. The language access plan must align with standards for communication and language assistance defined in the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health and Health Care (https://thinkculturalhealth.hhs.gov/clas).	High
COVID-19 Vaccine Achievement for Practice Staff	Demonstrate that the MIPS eligible clinician’s practice has maintained or achieved a rate of 100% of office staff in the MIPS eligible clinician’s practice fully COVID-19 vaccinated according to the Center for Disease Control and Prevention’s definition of fully vaccinated (https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-todate.html).	Medium

Improvement Activities Finalized for Removal

Improvement Activity Title	CMS’ Rationale
Participation in a QCDR, that promotes use of patient engagement tools	We propose to remove this activity under removal factor one, improvement activity is “duplicative.” We believe IA_BE_7 is duplicative because it is similar to, but only represents a partial component of, IA_PSPA_7.
Participation in a QCDR, that promotes collaborative learning network opportunities that are interactive	Same as above.
Use of QCDR for feedback reports that incorporate population health	Same as above.
Consultation of the Prescription Drug Monitoring program	We propose to remove this activity under removal factor one, improvement activity is “duplicative.” IA_PSPA_6 would be duplicative of the proposal to require the Query

	of PDMP measure for MIPS eligible clinicians in the Promoting Interoperability performance subcategory (measure PI_EP_2).
Leadership engagement in regular guidance and demonstrated commitment for implementing practice improvement changes	We propose to remove this activity under removal factor one, improvement activity is “duplicative.” We note that this proposed removal is being made in conjunction with our proposal to modify IA_PSPA_19 in Table B by adding the phrase “including leadership” to the activity description after “staffing” to capture the essence of IA_PSPA_20.
PCI Bleeding Campaign	We propose to remove this activity under removal factor seven, improvement activity is “obsolete.” The PCI Bleeding Campaign concluded on August 31, 2021, so this improvement activity will no longer be available as of the conclusion of the 2022 performance period.

Promoting Interoperability Performance Category

CMS reminded Promoting Interoperability participants to use the previously finalized definition of Certified Electronic Health Record Technology (CEHRT) during their 90-day performance period.

CMS finalized its proposal to require the previously optional “Query of Prescription Drug Monitoring Program (PDMP)” yes/no measure under the “Electronic Prescribing” objective. Additionally, the measure will expand to include Schedule III and IV drugs in addition to Schedule II opioids. Exclusions will be available for any MIPS eligible clinician who is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs during the performance period, for any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period, and for any MIPS eligible clinician for whom querying a PDMP would impose an excessive workflow or cost burden prior to the start of their performance period. An exclusion will result in redistribution of the measure’s 10 points to the “e-Prescribing” measure.

CMS finalized its proposal to add an optional “Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)” measure to enable satisfaction of the “Health Information Exchange (HIE)” objective. This yes/no measure will involve signing up with an entity in good standing that connects to a TEFCA-defined Qualified Health Information Network (QHIN), or a QHIN directly, and enabling secure, bidirectional exchange using CEHRT for encounters during the performance period.

CMS finalized modifications to the active engagement levels for the relevant measures under the “Public Health and Clinical Data Exchange” objective and requested that participants indicate their level of active engagement during attestation.

CMS finalized minor modifications to scoring the various objectives and measures for this category.

Advanced Alternative Payment Models

An Advanced APM is an APM that: 1) requires participants to use certified EHR technology (CEHRT), 2) provides payment for covered services based on quality measures comparable to MIPS, and 3) requires participating entities to bear more than nominal financial risk or participate as a Medical Home Model.

For payment years 2019 through 2024, Qualifying APM Participants (QPs) receive a 5 percent APM Incentive Payment. Starting in payment year 2026, the update to the PFS CF for QPs will be 0.75%. The Consolidated Appropriations Act, 2021, froze the APM payment incentive thresholds for performance years 2021 and 2022 (payment years 2023 and 2024). After performance year 2022, which correlates with payment year 2024, there is no further statutory authority for a 5 percent APM Incentive Payment for eligible clinicians who become QPs for a year. Beginning in payment year 2025, the statutory incentive structure under the QPP for eligible clinicians who participate in Advanced APMs stands in contrast to the incentives for MIPS eligible clinicians.

Generally Applicable Nominal Risk

In the CY 2017 Quality Payment Program (QPP) Final Rule, CMS established an 8% Generally Applicable Nominal Risk standard for Advanced APMs. CMS is removing the 2024 expiration of the 8% minimum on the Generally Applicable Nominal Risk standard for Advanced APMs and making the 8% minimum permanent.

Medical Home Model 50 Eligible Clinician Limit

CMS finalized policy to apply the 50 eligible clinician limits to the APM Entity participating in the Medical Home Model based on the TIN/NPIs on the APM Entity's participation list. Similarly, CMS is also applying the 50 eligible clinician limit directly to the APM Entity participating in Aligned Other Payer Medical Home Model and Medicaid Medical Home Model, and to no longer look to the parent organization for the APM Entity.

APM Entity level reporting of Promoting Interoperability Performance Category

CMS finalized policy to introduce a voluntary reporting option for APM Entities to report the promoting interoperability performance category at the APM Entity level beginning with the CY 2023 performance period.