

## **Medicare Physician Fee Schedule Proposed 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 proposed changes to the Medicare Physician Fee Schedule (MPFS) for calendar year (CY) 2023. The ACR will submit detailed comments to Centers for Medicare and Medicaid Services (CMS) by the September 6<sup>th</sup> comment period deadline. If finalized, the rule changes will be effective Jan. 1, 2023.

### **Conversion Factor and CMS Overall Impact Estimates (Page 1437)**

CMS estimates a CY 2023 conversion factor of \$33.0775 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 1.55 percent budget neutrality update. The budget neutrality update appears to be largely related to increased values for several evaluation and management code families, including hospital, emergency medicine, nursing facility and home visits.

CMS estimates an overall impact of the MPFS proposed changes to radiology to be a 3 percent decrease, while interventional radiology would see an aggregate decrease of 4 percent, nuclear medicine a 3 percent decrease and radiation oncology and radiation therapy centers a 1 percent decrease if the provisions within the proposed rule are finalized. Part of the decrease is due changes in relative value units (RVUs) and the second year of the transition to clinical labor pricing updates. 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.

### **Updates to Prices for Existing Direct Practice Expense (PE) Inputs (Page 32)**

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.

For 2023, CMS received invoices for several supply and equipment items from stakeholders. Based on the invoice submissions, CMS is proposing to update the prices for eight supplies and two equipment items. One of the supply items CMS is proposing to update is 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. These items do not pertain to radiology.

CMS continues to welcome stakeholder feedback on the updated pricing of supplies and equipment and will consider any new invoices submitted.

### **Clinical Labor Pricing Update** (Page 37)

The pricing for clinical labor staff had not been updated since 2002. In order to maintain relativity within the direct PE, since supplies and equipment are in the final year of transition, CMS initiated a four-year phase-in of updated pricing for clinical labor staff, beginning in 2022 and ending 2025. Data from the Bureau of Labor Statistics (BLS) was the primary source of clinical labor pricing information, but CMS also cross-walked or extrapolated wages from other sources such as Salary Expert.

For CY 2023, CMS is proposing to update the pricing of the Histotechnologist (L037B), for which they received data supporting a pricing increase. The pricing for the Histotechnologist is utilized in calculating the price for a Lab Tech/Histotechnologist (L035A), so this staff type also received a slight pricing increase from \$0.55 to \$0.60. As a result, the Angio Technician (L041A), which is included many radiology codes, also received a pricing increase from \$0.55 to \$0.60, as CMS previously established that L041A and L035A should be valued the same. No other changes were made to previously proposed clinical labor pricing.

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

### **Soliciting Public Comment on Strategies for Updates to Practice Expense Data Collection and Methodology** (Page 42)

CMS is soliciting for comments on how they might improve the collection of PE data inputs and refine the PE methodology. They acknowledge that while they have made some strides toward updating the supplies, equipment, and clinical labor pricing, some of the indirect PE inputs are over a decade old and would benefit from routine updates in order to avoid unpredictable shifts in payment.

CMS has worked with contractors to identify possible strategies to update the PE and believe that the indirect PE data inputs (rent, IT costs, and non-clinical expense) provide the opportunity to build transparency, consistency, and predictability into the PE methodology. The most recent data was last collected via the 2007 and 2008 Physician Practice Information Survey (PPIS) performed by the AMA.

CMS shared that they have contracted with RAND to assess potential improvements to the current PE methodology and that they (CMS) intend to move toward a standardized and routine approach to indirect PE valuation. CMS is soliciting stakeholder feedback on topics related to the identification of the appropriate instrument, methods, and timing for updating specialty-specific PE data. This would include comments related to representative sampling methods, survey design that would lend itself to transparency, and frequency and phase-in of adjustments to direct PE pricing.

CMS is also interested in comments about potential unintended impacts (positive or negative) that may result from changes to the PE methodology—such as concerns about beneficiaries’ access to care, the burden to small group or solo practitioners, or possible consolidation of group practices. They are requesting that feedback also includes discussion on health equity impacts.

**Potentially Misvalued Services Under the PFS** (Page 60)

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 131)

**Percutaneous Arteriovenous Fistula Creation (Current Procedural Terminology (CPT®) codes 368X1 and 368X2)** (Page 151)

Two new codes for Percutaneous Arteriovenous Fistula Creation were created by the CPT Editorial Panel: 368X1 (*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 368X2 (*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 368X1 and 368X2 represent two percutaneous approaches to creating arteriovenous access for End-Stage Renal Disease (ERSD) patients during hemodialysis. CMS is recommending that these codes replace HCPCS codes G2170 and G2171.

The RUC recommended a work RVU of 7.50 for CPT code 368X1 and a work RVU of 9.60 for CPT code 368X2. However, CMS does not agree with the RUC-recommended values, believing the values are high relative to other codes with similar intra-service time. Instead, CMS is proposing decreased work RVUs of 7.20 for CPT code 368X1, and 9.30 for CPT code 368X2, based on intra-service time ratio calculations. Per the RUC’s recommendation, CMS is proposing to delete HCPCS codes G2170 and G2171 and replace them with CPT codes 368X1 and 368X2 as recommended by the RUC.

For the direct PE inputs, CMS is requesting additional information on two equipment items: the Ellipsys EndoAVF generator (EQ404) used for CPT code 368X1 and the Wavelinq EndoAVF generator (EQ403) used for CPT code 368X2. Specifically, CMS would like comments on why EQ403 is so much more expensive than EQ404. Additionally, CMS is seeking information on four supply items: SD149 (catheter, balloon inflation device), SD152 (catheter, balloon, PTA), SF056 (detachable coil), and SF057 (non-detachable embolization coil). CMS would like feedback on the typicality of these supply items and how often they are used in these procedure(s).

**Somatic Nerve Injections (CPT codes 64415, 64416, 64417, 64445, 64446, 64447, 64448, 76942, 77002, and 77003) (Page 169)**

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*), CPT code 77003 (*Fluoroscopic guidance and localization of needle or catheter tip for spine or paraspinous diagnostic or therapeutic injection procedures (epidural or subarachnoid)*).

While CMS proposed refinements to some codes in the somatic nerve injection family, CMS is proposing the RUC-recommended work RVUs for the imaging CPT codes: 77002 (work RVU of 0.54), 77003 (work RVU of 0.60), and 76942 (work RVU of 0.67). CMS is proposing to accept the direct PE inputs for all of the codes in the somatic nerve injection code family as recommended by the RUC.

**Contrast X-Ray of Knee Joint (CPT Code 73580) (Page 182)**

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.

CMS is proposing 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 182)**

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 believed 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. CMS proposes the RUC-recommended work RVU of 0.79 for CPT code 76377. 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 requests 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 proposes the RUC-recommended direct PE inputs without refinement.

### **Neuromuscular Ultrasound (CPT codes 76881, 76882, and 76XX0) (Page 183)**

A new code for Neuromuscular Ultrasound was created by the CPT Editorial Panel: 76XX0 (*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 lieu of accepting the RUC-recommended values, CMS is proposing refined work RVUs of 0.54 for CPT code 76881, 0.59 work RVU for CPT code 76882, and 0.99 work RVU for CPT code 76XX0. The Agency states that the RUC-recommended values do not account for changes in the survey time or for appropriate comparisons for the new code, 76XX0. CMS applied a reverse building block methodology to reach their proposed work RVUs for the code family.

For direct PE inputs, CMS is proposing to remove the 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 because these RUC recommendations describe clinical labor activities that overlap with the E/M visit that is typically billed with CPT code 76881. CMS is proposing the direct PE inputs for CPT codes 76882 and 76XX0 as recommended by the RUC.

### **Evaluation and Management (E/M) Visits (Pages 297-351)**

#### **Background**

CMS has participated in a multi-year effort with the American Medical Association (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 (CCA), 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.

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 stated that final policies for the Other E/M visits will have a significant impact on relative resource valuation under the PFS. CMS proposes policies addressing coding and revaluation of Other E/M visits beginning for CY 2023. CMS also proposes a 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. Finally, CMS proposes a technical correction regarding how time is reported for split (or shared) critical care visits.

### **Overview of Policy Proposals**

CMS is proposing to adopt the revised CPT E/M Guidelines for Other E/M visits ([www.ama-assn.org/cpt-evaluation-management](http://www.ama-assn.org/cpt-evaluation-management)). CMS proposes to adopt the general CPT framework for Other E/M visits, such that time or MDM would be used to select the E/M visit level. History and physical exam would no longer be used to select visit level.

CMS would not adopt the general CPT rule where a billable unit of time is considered to have been attained when the midpoint is passed (CMS does not consider a service with a time descriptor of 30 minutes to have been satisfied if only 15 minutes of time had been spent furnishing that service). 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.

CMS is proposing to adopt the revised CPT codes and descriptors for Other E/M visits, except where otherwise specified. CMS would adopt the new 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 proposed G codes (one for each family for which prolonged services apply: inpatient/observation visits, nursing facility visits, and home or residence visits). CMS is proposing to adopt the CPT E/M Guidelines regarding MDM for E/M services. The CPT Editorial Panel revised the CPT E/M guidelines for levels of MDM, and CMS is proposing to adopt them as revised. In addition, CMS is maintaining its payment policy that physicians and NPPs are not classified as having the same specialty and subspecialties.

The 2021 CCA delayed Medicare payment for G2211 until at least January 1, 2024. CMS is proposing to adopt the RUC-recommended values for Other E/M visits beginning for CY 2023. CMS does not agree with the RUC that the current visit payment structure among and between care settings fully accounts for the complexity of certain kinds of 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.

### **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. The Panel deleted three initial observation care codes (99218, 99219, and 99220) and three subsequent observation care codes (99224, 99225, and 99226).

The Panel also revised the six hospital inpatient care codes 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, 99222, and 99223) and three subsequent inpatient or observation care codes (99231, 99232, and 99233). The CPT Editorial Panel also revised the three codes (99234, 99235, and 99236) under “Observation or Inpatient Care Services (including Admission and Discharge)”.

CMS proposes to adopt the revised CPT codes 99221 through 99223 and 99231 through 99236. CMS propose that, when a physician or practitioner selects CPT codes 99221 through 99223 and 99231 through 99236 based on time, the number of minutes specified in the descriptor must be “met or exceeded.” CMS is not proposing to adopt the CPT Codebook instructions regarding the application of prolonged codes to CPT codes 99223, 99233, and 99236. CMS also noted that the descriptors for CPT codes 99221 through 99223 and 99231 through 99236 specify that the time counted toward the code is “per day.” CMS proposes to adopt the 2023 CPT Codebook instruction that “per day,” also referred to as “date of encounter,” means the “calendar date.”

CMS also proposes 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 proposes 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.

*Proposed “8 to 24 Hour Rule”*

CMS proposes to retain the “8 to 24-hour rule” regarding payment of discharge CPT codes 99238 (Hospital inpatient or observation discharge day management; 30 minutes or less) and 99239 (more than 30 minutes).” This 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 proposes to retain is as follows:

- If the beneficiary receives less than 8 hours of hospital inpatient or observation services, the practitioner may not bill for hospital inpatient and observation discharge day management services (99238 and 99239). If a patient receives less than 8 hours of hospital inpatient or observation services, CMS proposes that the practitioner would bill only initial inpatient or observation care (99221, 99222, or 99223).
- If a beneficiary receives hospital inpatient or observation services for a minimum of 8 hours but less than 24 hours, CMS proposes that the practitioner would bill CPT codes 99234, 99235, or 99236.
- If a beneficiary is admitted for hospital inpatient or observation care and is then discharged after more than 24 hours, CMS proposes that the practitioner would bill an initial hospital inpatient or observation care code (99221 through 99223) for the date of admission, and a hospital discharge day management service code (99238 or 99239) on the date of discharge.

CMS believes it is necessary to retain the 8 to 24-hour policy to avoid overpayments or create incentives to unnecessarily extend beneficiaries’ hospital stays past midnight. See CMS’ examples for correct billing in the proposed rule.

*Proposed Definition of Initial and Subsequent Visit*

According to the 2023 CPT Codebook, 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 is proposing the same “initial” and “subsequent” definitions for nursing facility visits. CMS also proposes for both initial and subsequent visits, when advanced practice nurses and physician assistants are working with physicians, they are always classified in a different specialty than the physician.

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

CMS proposes to retain its current policy:

- 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. This policy aligns with language in the 2023 CPT Codebook instructions.
- If a patient is seen in a physician’s office on one date and receives care at a hospital (for inpatient or observation care) on the next date from the same physician, both visits are payable to that physician, even if less than 24 hours has elapsed between the 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, physician’s office, nursing facility), all services provided by the physician 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.
- A physician may bill only for an initial hospital or observation care service if the physician sees a patient in the ED and decides to either place the patient in observation status or admit the patient as a hospital inpatient.
- For patients in swing beds, 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 codes (CPT codes 99304 through 99316) apply.

### *Impact of Changes to Billing and Claims Processing Policies*

CMS proposes 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). **CMS seeks feedback from the public on potential challenges to billing or claims processing policies** for hospital inpatient or observation care as reflected in the Medicare Claims Processing Manual, Chapter 12, including possible impact on: billing for patients during a global period; documentation requirements; modifiers associated with hospital inpatient or observation care claims; and any other issues not otherwise discussed in this proposed rule that may need to be addressed through additional guidance.

### *Prolonged Services*

The CPT Editorial Panel made several changes to prolonged codes that previously could be billed with inpatient or observation codes. Effective January 1, 2023, codes 99356 (Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour; List separately in addition to code for inpatient or observation Evaluation and Management service) and 99357 (each additional 30 minutes), will be deleted and replaced with code 993X0 (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 services).

The 2023 CPT Codebook states, “Code 993X0 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 proposes not to adopt CPT code 993X0. CMS believes that the billing instructions for CPT code 993X0 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. Instead, CMS is proposing to create a single G-code that describes a prolonged service, and that applies to CPT codes 99223, 99233, and 99236. This G-code would be GXXX1.

- GXXX1 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 GXXX1 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0, 99415, 99416).  
(Do not report GXXX1 for any time unit less than 15 minutes).

CMS proposes that code GXXX1 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 proposed policy mirrors the policy the CPT Editorial Panel will apply to CPT code 993X0 (although CMS is not proposing to use CPT code 993X0 because 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 993X0 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. CMS proposes that the prolonged service period described by GXXX1 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, CMS proposes that GXXX1 prolonged code would be for a 15-minute increment, and the entire 15-minute increment must be completed in order to bill GXXX1. CMS proposes to round the time when the prolonged service period begins to the nearest 5 minutes. CMS provides examples of correct billing in the proposed rule (see pages 316 and 317). CMS summarizes prolonged services in Table 18.

**TABLE 18: Proposed Time Thresholds to Report Other E/M Prolonged Services**

Primary E/M Service	Prolonged Code*	Time Threshold to Report Prolonged	Count physician/NPP time spent within this time period (surveyed timeframe)
Initial IP/Obs. Visit (99223)	GXXX1	105 minutes	Date of visit
Subsequent IP/Obs. Visit (99233)	GXXX1	80 minutes	Date of visit
IP/Obs. Same-Day Admission/Discharge (99236)	GXXX1	125 minutes	Date of visit to 3 days after
IP/Obs. Discharge Day Management (99238-9)	n/a	n/a	n/a
Emergency Department Visits	n/a	n/a	n/a
Initial NF Visit (99306)	GXXX2	95 minutes	1 day before visit + date of visit +3 days after
Subsequent NF Visit (99310)	GXXX2	85 minutes	1 day before visit + date of visit +3 days after
NF Discharge Day Management	n/a	n/a	n/a
Home/Residence Visit New Pt (99345)	GXXX3	141 minutes	3 days before visit + date of visit + 7 days after
Home/Residence Visit Estab. Pt (99350)	GXXX3	112 minutes	3 days before visit + date of visit + 7 days after
Cognitive Assessment and Care Planning	n/a	n/a	n/a
Consults	n/a	n/a	n/a

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

CMS is proposing that GXXX1 would apply to both face-to-face and non-face-to-face time spent on the patient’s care within the survey timeframe. For CPT codes 99223 and 99233, this would be time spent on the date of encounter. For CPT code 99236, this would be time spent within 3 calendar days of the encounter. CMS is proposing that prolonged services without direct patient

contact would be reportable under GXXX1. CMS is proposing that CPT codes 99358 (Prolonged evaluation and management services before and/or after direct patient care, first hour) and 99359 (each additional 30 minutes) cannot be billed for base codes CPT codes 99221 through 99223 and 99231 through 99236. Direct patient care, as currently described by CPT codes 99358 and 99359, will be reportable under GXXX1.

### *Valuation of Services*

CMS proposes 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**

<b>CPT Code</b>	<b>Work RVUs</b>	<b>Total Time</b>
99221	1.63	40 minutes
99222	2.60	55 minutes
99223	3.50	74 minutes
99231	1.00	25 minutes
99232	1.59	36 minutes
99233	2.40	52 minutes
99234	2.00	50 minutes
99235	3.24	76 minutes
99236	4.30	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 the observation discharge code 99217 (Observation care discharge day management) and revised two hospital discharge day management codes 99238 (Hospital inpatient or observation discharge day management; 30 minutes or less) and 99239 (more than 30 minutes) so that codes 99238 and 99239 may be billable for discharge of hospital inpatient or observation patients.

CMS proposes to adopt the revised CPT codes 99238 and 99239, and expand it to include observation care. Specifically, CMS is proposing that CPT codes 99238 and 99239 are to be billed by the practitioner who is personally responsible for discharge service (or, in the case of the death of the patient, the physician who personally performs the death pronouncement); services furnished by other practitioners, including: instructions to the patient, communication with the family/caregiver, and coordination of post discharge services would be reported as subsequent hospital inpatient or observation care with CPT codes 99231, 99232, and 99233.

CMS proposes to retain its related policy that the same physician may not bill a hospital discharge CPT code 99238 or 99239 on the same day as a subsequent visit CPT codes 99231-99233.

*Prolonged Services and Hospital Inpatient or Observation Discharge Day Management*

CMS proposes that a practitioner would not be able to bill prolonged services for hospital discharge (99238 or 99239). CMS believes code descriptors for CPT codes 99238 and 99239 do not allow for additional payment of prolonged services. The descriptor for CPT code 99238 provides for hospital discharge day management, “30 minutes or less.” If a practitioner spends more than 30 minutes on a hospital discharge service for a patient, the practitioner would be able to bill CPT code 99239, which is defined in the code descriptor as “30 minutes or more.” Thus, a prolonged code (including CPT codes 993X0, 99358, 99359, and code GXXX1) would not be appropriate for CPT code 99238, because CPT code 99239 accounts for services that exceed 30 minutes. The descriptor for CPT code 99239 states that the code is for “30 minutes or more” of hospital discharge day management services.

When the RUC surveyed this code, the surveyed timeframe was within 3 calendar days of the encounter. In other words, the descriptor time is 30 minutes or more, completed within 3 calendar days of the encounter. Neither the descriptor nor the CPT billing instructions provide an upper limit on how many minutes can be reported within the 3-day timeframe for CPT code 99239. All face-to-face and non-face-to-face activities performed by the practitioner during the date of encounter and within 3 calendar days from the date of encounter may be counted toward CPT code 99239, as applicable. Prolonged codes CPT codes 993X0, 99358, 99359 and the proposed GXXX1 code are intended to pay for time not included in the base E/M codes during the surveyed timeframe; as it appears that CPT code 99239 already includes all services furnished during the surveyed timeframe, we do not believe it is appropriate to allow any prolonged codes to be billed with CPT code 99239 as a base code.

*Valuation of Hospital Inpatient or Observation Discharge Day Management*

CMS proposes to accept the RUC recommendations for CPT 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). CMS is proposing the RUC-recommended direct PE inputs for codes 99238 and 99239.

**Emergency Department (ED) Visits (CPT Codes 99281-99285)**

*Coding*

Effective January 1, 2023, the CPT Editorial Panel revised five ED visit codes to allow the level of service selection based on MDM. Code 99281 was revised and may not require the presence of a physician or other qualified health care professional. The MDM level in the descriptor for code 99282 was revised from “low” to “straightforward” complexity, and from “moderate” to “low” complexity for CPT code 99283.

*Sites of Service and Multiple Same-Day E/M Visits for Emergency Department Patients*

CMS proposes to modify its policy regarding when to bill ED codes CPT codes or hospital inpatient care (99221 through 99223) to clarify that these policies apply to observation care billed under CPT codes 99221 through 99223 as well.

CMS proposes that if a physician advises their own patient to go to an ED of a hospital for inpatient care or observation and the physician subsequently 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 the patient's personal physician should bill only the appropriate level of the initial hospital inpatient or observation care (CPT codes 99221 - 99223), because all E/M services provided by that physician 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. The ED physician who saw the patient in the ED should bill the appropriate level of the ED codes.
- If the ED physician, based on the advice of the patient's personal physician who came to the ED to see the patient, sends the patient home, then the ED physician shall bill the appropriate level of ED service. The patient's personal physician shall also bill the level of ED code that describes the service they provided in the ED. If the patient's personal physician does not come to the hospital to see the patient, but only advises the ED physician by telephone, then the patient's personal physician may not bill the ED codes.

Similarly, CMS proposes that if the ED physician requests that another physician evaluate a given patient, the other physician should bill an ED visit code. Also, if the patient is admitted by the second physician performing the evaluation, that physician shall bill an initial hospital inpatient or observation care code (99221- 99223), and not an ED visit code. This policy applies to both hospital inpatient and observation care billed under CPT codes 99221 through 99223.

The 2023 CPT Codebook includes instructions that critical care and ED services may be billed on the same day under certain circumstances. Refer to CMS' finalized policy in the 2022 PFS final rule 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. Use modifier -25 on the claim when reporting critical care services.

#### *Valuation*

CMS proposes the RUC-recommended work RVU for four of the five codes in the ED Visits family (99281=work RVU of 0.25, 99282= work RVU of 0.93, 99283= work RVU of 1.60, 99285= work RVU of 4.00).

CMS disagrees with the RUC-recommended work RVU of 2.60 for CPT code 99284 and is proposing to maintain the current work RVU of 2.74. CMS believes that the levels 4 and 5 ED visits are more accurately valued higher than the levels 4 and 5 new patient O/O E/M visits to reflect their higher typical intensity.

There are no direct PE inputs for these five ED visit codes.

### *Prolonged Services*

CMS is proposing that the prolonged services (HCPCS codes GXXX1- GXXX3) would not be reportable with ED visit codes since 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 CPT 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 is proposing 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 is proposing to adopt a number of billing policies:

- The required initial comprehensive assessment shall be billed as an initial NF care visit (99304-99306). CMS proposes that a practitioner may bill the most appropriate initial nursing facility care code (99304- 99306) or subsequent nursing facility care code (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. CMS is proposing to allow for an initial or subsequent NF visit to be furnished and billed by the appropriate practitioner (physician, physician assistant, nurse practitioner, or clinical nurse specialist regardless of whether the initial comprehensive assessment was performed.
- CMS proposes to retain its policy to not pay a physician for an ED visit or an office visit and a comprehensive nursing facility assessment on the same calendar day, since it would be duplicative care. The services furnished on the same date and provided in sites other than the nursing facility are already bundled into the initial nursing facility care code when performed on the same date as the nursing facility admission by the same physician.

CMS is proposing that more than one ED and nursing facility visit could not be billed if both visits are furnished by the same practitioner on the same date of service.

CMS proposes that, for reporting initial nursing facility care, transitions between skilled nursing facility level of care and nursing facility level of care do not constitute a new stay.

CMS proposes the same definition for “initial” and “subsequent” for nursing facility care as it proposed for inpatient and observation services.

### *Valuation*

CMS is proposing 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). However, **CMS seeks comment on the accuracy of the time noted in the descriptor for CPT code 99306.** CMS considered maintaining the current work RVU of 3.06 instead of the RUC-recommended value of 3.50 since there was no change in the overall time.

### *Prolonged Services*

CMS is proposing that prolonged nursing facility services by a physician or NPP would be reportable under GXXX2, which would be used when the total time (in the time file) is exceeded by 15 or more minutes to account for the additional time spent.

- GXXX2 Prolonged nursing facility 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 99306, 99310 for nursing facility evaluation and management services).

(Do not report GXXX2 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0).

(Do not report GXXX2 for any time unit less than 15 minutes).

CMS proposes that the practitioner would include any prolonged service time spent within the surveyed timeframe (the day before the visit, the day of the visit, and up to and including 3 days after the visit). CMS is proposing that prolonged physician or NPP NF services would be reportable when the total time (in the physician time file) is exceeded by 15 or more minutes which would be once 95 minutes are spent for initial NF visits, and once 85 minutes are spent for subsequent NF visits, and for each additional 15 minutes furnished thereafter with no frequency limitation. Therefore, CMS is proposing that physicians and NPPs would be able to bill GXXX2 for each additional 15-minute increment of time beyond the total time for CPT codes 99306 and 99310.

CMS is proposing to change the payment status for CPT codes 99358 and 99359 (prolonged E/M visit without direct patient contact) to “I” (Not valid for Medicare purposes. Medicare uses another code for reporting of, and payment for, these services). GXXX2 includes time without direct patient contact, there would no longer be a need to use CPT codes 99358 and 99359 in conjunction with NF visits.

### **Nursing Facility Discharge Management (CPT Codes 99315-99316)**

#### *Coding*

Codes 99315 (Nursing facility discharge day management; 30 minutes or less) and 99316 (Nursing facility discharge day management; more than 30 minutes) 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 is proposing 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 proposed the RUC-recommended work RVU of 1.50 for code 99315 and work RVU of 2.50 for code 99316. CMS is proposing the RUC-recommended direct PE inputs for CPT code 99315 and the RUC-recommended direct PE inputs for CPT code 99316.

#### *Prolonged Services*

CMS proposes 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 is proposing to accept the deletion of code 99318. Instead, codes 99308, 99309, 99310 could be used to report the required annual visit.

**CMS is seeking comment on whether there is a need to keep this code for Medicare purposes.** CMS is concerned that the absence of a similar code could cause an unwarranted increase in valuation of other services under the PFS, and CMS would not have a means of tracking how often these visits are occurring.

#### *Valuation*

Given the proposed 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.

### **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.

#### *Valuation*

CMS proposes the RUC-recommended work RVU for all eight CPT codes (99341, 99342, 99344, 99345, 99347-99350). CMS is proposing the RUC-recommended direct PE inputs for CPT codes 99345, and 99347-99350 without refinement. 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 is proposing that prolonged home or residence services by a physician or NPP would be reportable under GXXX3

- GXXX3 Prolonged home or residence 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 99345, 99350 for home or residence evaluation and management services).

(Do not report GXXX3 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417).

(Do not report GXXX3 for any time unit less than 15 minutes).

Report code GXXX3 when the total time (in the time file) is exceeded by 15 or more minutes. Report prolonged add-on code GXXX3 to code 99345 or 99350 once the practitioner spends 15+ minutes beyond the total time finalized for the primary service (in time file).

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 is proposing to change the status indicator for codes 99358 and 99359 to "I," (not valid for Medicare purposes, and that Medicare uses another code for reporting of, and payment for, these services) since CMS is proposing that prolonged services with or without direct patient contact would be reportable under GXXX3.

## **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 proposes a slight increase from the current 3.80 to 3.84 to account for the increase in physician time. CMS proposes the RUC-recommended PE inputs.

### *Prolonged Services*

CMS proposes that prolonged services would not be reported with CPT code 99483 since it has a typical time in its descriptor, which is not necessarily the actual time spent.

## **Prolonged Services Valuation**

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

The CPT Editorial Panel is deleting CPT codes 99354-99357. CMS is proposing to accept this deletion.

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

CMS is proposing 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 proposes the RUC recommended direct PE inputs.

### *Valuation of Prolonged Other E/M Services (HCPCS Codes GXXX1, GXXX2 and GXXX3)*

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 is proposing that the three prolonged visit HCPCS G codes GXXX1 - GXXX3 be valued identically across settings, based on the RUC recommended value for CPT code 99417. CMS is proposing a 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 proposes to continue its longstanding policies, included in the Medicare Claims Processing Manual (Pub. 100-04), Chapter 12, for 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 proposes 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 is proposing 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 proposes 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.

### **Revising the Medicare Economic Index (Page 458)**

The proposed rule includes 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 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 recognizes the need to update the MEI cost weights, but proposes 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 is proposing 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.

Table 148 in the proposed rule provides estimated impacts of the proposed rebased and revised MEI cost share weights by specialty, both if the changes were to be phased in over time 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 work with its consultants to decipher the details of these proposals and their impacts and will offer comments to CMS.

### **Payment for Medicare Telehealth Services** (pg. 76)

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.

For CY 2023, CMS proposes several policies related to Medicare telehealth services including making some 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 proposes to add services to the Medicare Telehealth Services List on a Category 3 basis; these services are currently included on the telehealth list on a temporary basis during the PHE. This additional time would allow CMS to evaluate data that may support their permanent

addition to the list on a Category 1 or Category 2 basis. Table 8 within the proposed rule includes the 53 services CMS proposes as Category 3 telehealth services.

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

CMS proposes 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 10 in the rule lists the services that this extension would apply to. CMS believes this proposal would simplify the process of when flexibilities will end and minimize possible errors. CMS noted that on the 152<sup>nd</sup> day after the end of the PHE, payment will no longer be available for these services.

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

Prior to the PHE, direct supervision of diagnostic tests, services incident to physician services, and other specified services required the immediate availability of the supervising physician or other practitioner. CMS interpreted this “immediate availability” to mean in-person, physical availability and not virtual availability. During the PHE, CMS changed the definition of “direct supervision” to allow the supervising professional to be immediately available through a virtual presence using real-time audio/video technology for the direct supervision of diagnostic tests, physicians’ services and some hospital outpatient services.

CMS is seeking comments regarding the possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time, audio/video technology for only a subset of services. CMS recognizes that it may be inappropriate to allow direct supervision without physical presence for some services due to potential concerns over patient safety.

### **Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers** (Page 576)

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 then goes on to propose expanding 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 proposes 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. If finalized, this means that the colonoscopy is paid at 100% without patient cost sharing.

#### *Background*

CMS stated in the proposed rule that in calendar year 2019, CRC had the 4<sup>th</sup> highest rate of new cancer cases and the 4<sup>th</sup> 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. This proposed rule seeks to change that.

#### *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.

#### *Proposed Revisions*

CMS proposes 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. 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 invites public comment on this proposal.

CMS also proposes 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 proposal 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 is not proposing 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 proposed 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."

### **Medicare Shared Savings Program (MSSP) (page 615)**

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. 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 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.

Through the changes proposed changes in this rule, CMS seeks to reverse certain recent trends in in the MSSP: in recent years growth in the number of beneficiaries assigned to ACOs has plateaued; higher spending populations are increasingly underrepresented in the program since the change to regionally-adjusted benchmarks; and access to ACOs appears inequitable as shown by data indicating that Black (or African American), Hispanic, Asian/Pacific Islander, and



American Indian/Alaska Native beneficiaries are less likely to be assigned to a Shared Savings Program ACO than their Non-Hispanic White counterparts.

### **Shared Savings Program Participation Options**

#### *Increasing Participation in Accountable Care Models in Underserved Communities by Providing an Option for Advance Investment Payments to Certain ACOs*

CMS proposes to make advance shared savings payments—referred to as advance investment payments (AIPs)—to certain ACOs participating in the Shared Savings Program, to improve the quality and efficiency of items and services furnished to Medicare beneficiaries. CMS proposes to limit eligibility for AIP funding to new ACOs and ACOs inexperienced with performance-based risk Medicare ACO initiatives. CMS is also broadening the eligibility criteria compared to AIM to reflect its belief that it is important to provide an incentive for providers and suppliers who serve high need beneficiaries in all areas to form ACOs, including underserved beneficiaries who reside in urban areas. Therefore, CMS does not limit the opportunity for an ACO to receive AIPs to ACOs in only rural communities or in areas with low ACO penetration.

#### *Smoothing the Transition to Performance-Based Risk in ACOs*

Since 2012, the MSSP has included both one-sided financial models (also known as shared savings only, or upside only) and two-sided financial models (shared savings and shared losses, or upside and downside risk) for ACOs to select based on the arrangement that makes the most sense for their organization. In response to several commenters' concerns that requiring the rapid assumption of significant levels of risk by ACOs would discourage new participants and impede current ACOs' ability to make patient-centered infrastructure investments that are necessary for successful participation, CMS had stated its commitment to continue to monitor program participation and consider further refinements to the program's participation options. CMS believes it would be prudent to provide greater flexibility for ACOs to join the program under one-sided risk and to remain in the program under lower levels of performance-based risk in order to balance CMS' desire to see more ACOs participate under performance-based risk while also working toward the goal of increasing overall MSSP participation and improving outcomes for beneficiaries. CMS proposes to allow certain ACOs more time under a one-sided model and more flexibility in transitioning to higher levels of risk and potential reward by modifying the participation options available under the Shared Savings Program.

#### *Quality Performance Standard and Reporting Requirements*

The MSSP quality performance standard is used to determine whether an ACO is eligible to receive shared savings for a performance year (PY). Due to prior rulemaking, the standard's performance parameters and its associated reporting requirements are set to gradually increase during PY 2023 and PY 2024 before stabilizing for PY 2025 and subsequent years. CMS proposes to add an alternative quality performance standard, base shared savings and loss amounts on sliding scales, and extend the transition period's existing incentive for reporting the APP measures. CMS also proposes to implement a health equity adjustment to ACO quality scores based on beneficiary dual eligibility and residence in a disadvantaged neighborhood.

*Health Equity Adjustment*

CMS proposes to adopt a health equity adjustment into the Shared Savings Program beginning with PY 2023. The adjustment would be incorporated into calculation of quality performance scores and shared savings and losses and into the extreme and uncontrollable circumstances policy. CMS further proposes that ACO eligibility for the adjustment would be determined by the proportion of assigned beneficiaries that are dually eligible or reside in disadvantaged neighborhoods and would be restricted to ACOs with relatively higher quality performance scores. The adjustment would be implemented through two proposed quality performance score adjusters and be capped at 10 points. CMS proposes to specify that the health equity-adjusted quality performance score would be taken into consideration when determining the quality performance score and calculating shared savings/shared loss reductions for an ACO that has been affected by extreme and uncontrollable circumstances.

*Ongoing Consideration of Concerns About the Impact of the Public Health Emergency (PHE) for COVID-19 on ACOs' Expenditures*

In the March 31st COVID-19 IFC, CMS removed the restriction which prevented the application of the MSSP extreme and uncontrollable circumstances (EUC) policy for disasters that occur during the quality reporting period if the reporting period is extended, to offer relief under the MSSP to all ACOs that may have been unable to completely and accurately report quality data for 2019 due to the PHE for COVID-19.

As a result of forgoing the 2021 application cycle for new applications, agreement periods starting in 2022 are the first agreement periods for which 2020 and 2021 serve as benchmark years for ACOs in MSSP. Interested parties have expressed concern that the policy adjustments made in response to the PHE for COVID-19 may not fully address the potential for relatively lower expenditures resulting from lower utilization by non-COVID-19 patients. This decrease in utilization and expenditures could result in relatively lower benchmark year expenditures for ACOs in agreement periods beginning in 2022, 2023 or 2024 for which 2020 and/or 2021 are benchmark years. CMS believe that the current blended national-regional trend and update factors will be sufficient to address and mitigate the impact of the start of the PHE for COVID-19 on benchmark year expenditures. CMS seeks comment on this analysis regarding the impact of the PHE for COVID-19 on Shared Savings Program ACOs' expenditures.

*Proposed Supplemental Payment for Indian Health Service and Tribal Hospitals and Hospitals located in Puerto Rico (pg. 927)*

In the FY 2023 IPPS/LTCH PPS proposed rule, CMS proposed the exceptions and adjustments authority under section 1886(d)(5)(I) of the Act to establish a new supplemental payment for IHS/Tribal hospitals and hospitals located in Puerto Rico, beginning in FY 2023. In order to align MSSP policies with updates made to Medicare FFS payment policies, CMS proposes to exclude this supplemental payment for 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 MSSP. CMS proposes to similarly include the proposed supplemental payment to IHS/Tribal hospitals and hospitals located in Puerto Rico in such calculations for the performance year beginning January 1, 2023, and subsequent performance years. CMS stated by

removing the proposed supplemental payment for IHS/Tribal hospitals and hospitals located in Puerto Rico from performance year expenditures they will be able to reward more accurately actual decreases in unnecessary utilization of health care services.

CMS seeks comment on this proposed change to the determination of Medicare Parts A and B expenditures for purposes of calculations under MSSP, including the determination of benchmark and performance year expenditures, as well as the calculation of ACO participant revenue.

*Seeking Comment on Incorporating Administrative Benchmarking Approach into the Shared Savings Program*

CMS seeks comment on an alternative approach to calculating ACO historical benchmarks that would use administratively set benchmarks that are decoupled from ongoing observed FFS spending. Throughout this discussion, CMS provides additional background and information on factors for consideration, as well as solicits public input on a range of related questions and considerations.

**Updates to the Quality Payment Program (QPP)**

Within this rule, CMS limits proposals for traditional MIPS and focuses on further refining the implementation of MIPS Value Pathways (MVPs), gathering 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** (Page 1108)

This proposed rule includes a new request for information (RFI) on dQM, a concept introduced in the calendar year 2022 proposed rule. In the RFI, CMS provides information and seeks comment on transitions to FHIR standardized terminologies within the 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 addition to updates to CMS' dQM definition, CMS requests comments on suggested implementation guides, approaches to optimize data flows for quality measurement to retrieve data from EHRs via FHIR APIs, and data aggregation methods.

**Transforming MIPS: MVP Strategy** (Page 1124)

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).

Through 30-day comment periods, **CMS proposes to collect public input on candidate and established MVPs.** The comment periods would be separate from the rulemaking process. For candidate MVPs, CMS would collect public feedback and potentially revise MVPs before subjecting them to rulemaking. CMS would 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 would 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 proposes 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.

**The rule contains multiple proposed updates addressing subgroup reporting.** These include 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 (Page 1267)**

The proposed 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 (Page 1281)**

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 proposing a 75-point performance threshold, which is an increase from the 2021 60-point threshold and 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 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.

CMS finalized the payment adjustment of +/- 9% for performance years 2020 and beyond. No changes have been proposed to the MIPS adjustment.

#### **Low-Volume Threshold and Small Practice (15 or fewer eligible clinicians) Considerations (Page 1148)**

CMS has not proposed 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 proposes retaining 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 (Page 1164)**

**CMS has not proposed 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 Proposed for Addition and Removal (Page 1700)**

**CMS proposes removing 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

**CMS also proposes adding the following new measure to the Diagnostic Radiology and Radiation Oncology measure sets:**

- #TBD: Screening for Social Drivers of Health

**Additionally, CMS proposes 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 (Page 1169)**

CMS did not propose changes to the data completeness requirements; 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. **CMS is proposing to increase this threshold to 75% beginning with the 2024 performance year.**

#### **Cost Performance Category (Page 1187)**

**CMS is proposing 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 (Page 1106)**

**CMS has not proposed any major changes to the Improvement Activities performance category.** This category will remain weighted at 15% as in previous years. CMS has proposed 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) is proposed to be updated to comprise elements of the removed IAs. The new description of IA\_PSPA\_7 is proposed 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 preventative screening and vaccinations that can be shared across MIPS eligible clinician 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 social determinants of health such as food security, employment, and housing;

- 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 for adverse outcomes after an outpatient surgical procedure and corrective steps to address adverse outcomes.”

Improvement Activities Proposed 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, 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.	High
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 ( <a href="https://thinkculturalhealth.hhs.gov/clas">https://thinkculturalhealth.hhs.gov/clas</a> ).	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 ( <a href="https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html">https://www.cdc.gov/coronavirus/2019-ncov/vaccines/stay-up-to-date.html</a> ).	Medium
---	--	--------

**Improvement Activities Proposed for Removal.**

<b>Improvement Activity Title</b>	<b>CMS’ Rationale</b>
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 (Page 1199)**

CMS has not proposed to change the Promoting Interoperability performance period for the CY 2025 MIPS payment year, which would be a minimum of any continuous 90-day period within CY 2023. Participants reporting this category would be required to use the previously finalized



definition of Certified Electronic Health Record Technology (CEHRT) during their chosen 90-day performance period.

CMS proposes to require the previously optional “Query of Prescription Drug Monitoring Program (PDMP)” yes/no measure under the “Electronic Prescribing” objective. Additionally, the measure would be expanded to include Schedule III and IV drugs in addition to Schedule II opioids. Proposed exclusions would be for any MIPS eligible clinician who is unable to electronically prescribe Schedule II opioids and Schedule III and IV drugs during the performance period, and for any MIPS eligible clinician who writes fewer than 100 permissible prescriptions during the performance period. An exclusion for this measure would result in redistribution of the measure’s 10 points to the “e-Prescribing” measure.

CMS proposes a new optional “Enabling Exchange under the Trusted Exchange Framework and Common Agreement (TEFCA)” measure which would enable satisfaction of the “Health Information Exchange (HIE)” objective. This yes/no measure would involve signing up with an entity that connects to a TEFCA-defined Qualified Health Information Network (QHIN), or a QHIN directly, and enabling bidirectional exchange using CEHRT for encounters during the performance period. CMS also requested comments on additional ways to advance information exchange via TEFCA-participating networks.

CMS proposes 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.

Finally, CMS proposes minor scoring changes to the category’s various measures and objectives and proposes discontinuing automatic reweighting of certain non-physician practitioner MIPS eligible clinician types, such as physician assistants and nurse practitioners.

ACR staff continue to further analyze the proposed rule and will be submitting comments to CMS by September 6<sup>th</sup> deadline.