

CMS RELEASES CY 2023 MEDICARE PHYSICIAN FEE SCHEDULE PROPOSED RULE

On Thursday, July 7th, the Centers for Medicare & Medicaid Services (CMS) released the CY 2023 Medicare Physician Fee Schedule (MPFS) [proposed rule](#) and [fact sheet](#). This rule outlines the agency's proposed payment and quality program policies for the upcoming year, and this year's rule includes important policy proposals and requests for feedback. The Endocrine Society is reviewing the rule in its entirety and will be developing comments, which are due on September 6.

Some highlights of the rule include the following:

- **Conversion Factor:** The conversion factor for 2023 is set to decrease by approximately **4.5% from \$34.6026 to \$33.0775**. The decrease is due to the expiration of the 3% increase to payments which was enacted by Congress last year but is due to expire at the end of 2022, which is then coupled with budget neutrality adjustments and a mandated 0% increase. This conversion factor decrease is coupled with a mandated 4% cut across the Medicare program, including the MPFS, mandated by Congress' pay-as-you-go rule. Without Congressional action, which is not expected before the end of the year, CMS does not have the authority to increase the conversion factor or alleviate the other 4% cut. The Endocrine Society will be calling on members to take action to stop these cuts later in the year.
- **Evaluation and Management (E/M) Services:** CMS is proposing to adopt nearly all the revisions for CPT[®] codes used to report other E/M visits including inpatient and observation services. The changes include revisions to the documentation guidelines and to the descriptors for these services, which will now mirror the revisions previously made to the outpatient E/M services. Inpatient E/M code level may be chosen based on time or medical decision making, and like the outpatient E/M codes, using the history and exam to determine code level has been eliminated. However, physicians will not see significant increases in the values of these services, particularly compared to what happened with the outpatient family, because of the cuts described above.
- **Telehealth:** CMS continues to support the use of telehealth in treating Medicare patients during the public health emergency. As such, the agency is proposing to retain certain services on the telehealth list through 2023 to allow for data collection so the agency may better understand the use of telehealth services within the Medicare program. Also included is a proposal to extend the use of codes that were placed on a temporary-approved telehealth list during the pandemic. The codes on the temporary list will be available for reporting telehealth services for 151 days at the end of the PHE. The agency also outlined the appropriate modifiers that should be appended to telehealth services after the 151-day extension expires and solicited comments on making virtual direct supervision permanent.
- **New G-Codes for the 180-Day Implantable Interstitial Glucose Sensor System:** Since the Food and Drug Administration recently approved the new 180-day system, CMS has released two G-codes for billing the use of the system. These codes were effective July 1st and are contractor priced. CMS is requesting that stakeholders submit receipts to determine the appropriate practice expense reimbursement for the new system.
- **Potentially Underutilized Services – Diabetes Self-Management Training:** CMS pays for services that support beneficiaries' health and well-being, which may also have the benefit of reducing spending: Diabetes Self-Management Training (DSMT) is one of those services. These services,

however, may be underutilized, and the agency is soliciting comment on how to improve access to underutilized, high value services and mitigate any obstacles to their adoption.

- **Quality Payment Program:** The agency intends to implement the Merit-Based Incentive Payment System (MIPS) Value Pathways as a voluntary option in CY 2023 with 12 proposed pathways, none of which are specific to endocrinology. This program is CMS' answer to make participation in the MIPS program more coherent and meaningful. The agency included requests for information related to the MIPS program including developing and implementing health equity measures for the MIPS quality performance category and how to incorporate technological advancements into the quality reporting program. The Advanced Alternative Payment Model (APM) incentive payment expires at the end of 2022, and in response, CMS requests feedback on whether administrative action is needed to address these challenges beginning in CY 2024.
- **Health Equity Initiative:** CMS is seeking feedback on the inclusion of two new measures in the APM performance pathway measure set: 1) screening for social drivers of health and 2) screen positive rate for social drivers of health. Specifically, the agency asks for comments on the value of these measures, how to implement them, what barriers might impede implementation, what flexibilities should be considered when implementing the measures, and what impact these measures will have on providing care to underserved populations.
- **Principles for Measuring Health Care Quality Disparities:** CMS included a request for information on issues that should be considered when advancing measurement and stratification as tools to address health care disparities and improve health equity.

This [chart](#) shows the impact of the proposed rule on services commonly billed by endocrinologists.