CMS Manual System	**Department of Health & Human Services (DHHS)**
Pub 100-04 Medicare Claims Processing	**Centers for Medicare & Medicaid Services (CMS)**
Transmittal 11708	**Date: November 17, 2022**
	Change Request 12982

SUBJECT: Summary of Policies in the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) Final Rule, Telehealth Originating Site Facility Fee Payment Amount and Telehealth Services List, CT Modifier Reduction List, and Preventive Services List

I. SUMMARY OF CHANGES: The purpose of this Change Request (CR) is to provide a summary of the policies in the CY 2023 Medicare Physician Fee Schedule (MPFS) Final Rule and to announce the Telehealth Originating Site Facility Fee payment amount. The attached recurring update notification applies to publication 100-04, chapter 12, section 190.5, chapter 13, section 20.2.4, and chapter 18, section 240.

EFFECTIVE DATE: January 1, 2023
**Unless otherwise specified, the effective date is the date of service.*
IMPLEMENTATION DATE: January 3, 2023

Disclaimer for manual changes only: The revision date and transmittal number apply only to red italicized material. Any other material was previously published and remains unchanged. However, if this revision contains a table of contents, you will receive the new/revised information only, and not the entire table of contents.

II. CHANGES IN MANUAL INSTRUCTIONS: (N/A if manual is not updated)
R=REVISED, N=NEW, D=DELETED-*Only One Per Row.*

R/N/D	CHAPTER / SECTION / SUBSECTION / TITLE
N/A	N/A

III. FUNDING:
For Medicare Administrative Contractors (MACs):
The Medicare Administrative Contractor is hereby advised that this constitutes technical direction as defined in your contract. CMS does not construe this as a change to the MAC Statement of Work. The contractor is not obligated to incur costs in excess of the amounts allotted in your contract unless and until specifically authorized by the Contracting Officer. If the contractor considers anything provided, as described above, to be outside the current scope of work, the contractor shall withhold performance on the part(s) in question and immediately notify the Contracting Officer, in writing or by e-mail, and request formal directions regarding continued performance requirements.

IV. ATTACHMENTS:

Recurring Update Notification

Attachment - Recurring Update Notification

Pub. 100-04	Transmittal: 11708	Date: November 17, 2022	Change Request: 12982

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I. GENERAL INFORMATION

A. Background: The purpose of this Change Request (CR) is to provide a summary of the policies in the CY 2023 MPFS. Section 1848(b)(1) of the Social Security Act (the Act) requires the Secretary to establish by regulation a fee schedule of payment amounts for physicians' services for the subsequent year. The Centers for Medicare & Medicaid Services (CMS) issued a final rule that updates payment policies and Medicare payment rates for services furnished by physicians and Nonphysician Practitioners (NPPs) that are paid under the MPFS in CY 2023. The final rule also addresses public comments on Medicare payment policies proposed earlier this year.

B. Policy: CMS issued regulation number CMS-1770-F, Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts. This CR provides a summary of the payment polices under the MPFS and makes other policy changes related to Medicare Part B payment. These changes are applicable to services furnished in CY 2023.

<u>Medicare Telehealth Services</u>

For CY 2023, CMS is adding new Healthcare Common Procedure Coding System (HCPCS) codes to the list of Medicare telehealth services on a Category 1 basis, specifically HCPCS codes G0316, G0317, G0318, G3002, and G3003. We are retaining many services that are temporarily available as telehealth services for the duration of the PHE on a Category 3 basis through CY 2023; these are Current Procedural Terminology (CPT) codes 90875, 90901, 92012, 92014, 92550, 92552, 92553, 92555 - 92557, 92563, 92567, 92568, 92570, 92587, 92588, 92601, 92625 - 92627, 94005, 95970, 95983, 95984, 96105, 96110, 96112, 96113, 96127, 96170, 96171, 97129, 97130, 97150 - 97158, 97530, 97537, 97542, 97763, 98960 - 98962, 99473, 0362T, and 0373T. The status of these codes on the Medicare Telehealth Services List will change to, "Available up Through December 31, 2023." We are extending the duration of time that services are temporarily included on the Medicare Telehealth Services List during the Public Health Emergency (PHE), but are not included on a Category I, II, or III basis for a period of 151 days following the end of the PHE, in alignment with the Consolidated Appropriations Act, 2022 (CAA, 2022).

We are implementing the 151-day extensions of Medicare telehealth flexibilities in the CAA, 2022, including allowing telehealth services to be furnished in any geographic area and in any originating site setting, including the beneficiary's home, allowing certain services to be furnished via audio-only telecommunications systems, and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to furnish telehealth services. The CAA, 2022 also delays the in-person visit requirements for mental health services furnished via telehealth until 152 days after the end of the PHE.

For 2023, we are implementing that telehealth claims may continue to be billed with the place of service indicator of what it would have been had the service been billed for an in-person visit. These claims will require the modifier "95" to identify them as services performed and provided as telehealth services through the later of the end of CY 2023 or end of the year in which the PHE ends.

The list of codes that are added to the telehealth services list can be found at:
https://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes

For more information regarding telehealth services, please contact Patrick Sartini at- (410)786-9252.

Telehealth origination site facility fee payment amount update

Section 1834(m)(2)(B) of the Act establishes the payment amount for the Medicare telehealth originating site facility fee for telehealth services provided from October 1, 2001, through December 31, 2002, at $20. For telehealth services provided on or after January 1 of each subsequent calendar year, the telehealth originating site facility fee is increased by the percentage increase in the Medicare Economic Index (MEI) as defined in section 1842(i)(3) of the Act. The MEI increase for 2023 is 3.8 percent. Therefore, for CY 2023, the payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80 percent of the lesser of the actual charge, or $28.64 (The beneficiary is responsible for any unmet deductible amount and Medicare coinsurance).

For more information regarding Telehealth Services, contact Patrick Sartini at- (410)-786-9252.

Evaluation and Management (E/M) Visits

For CY 2023, we are finalizing changes for Other E/M visits that parallel the changes we made in recent years for office/outpatient E/M visit coding and payment.

Coding

Other E/M visits include hospital inpatient, hospital observation, emergency department, nursing facility, home services, residence services, and cognitive impairment assessment visits. For 2023, we are adopting the revised CPT codes for Other E/M visits (except for prolonged services). This includes:

- Merger of hospital inpatient and observation visits into a single code set, and merger of domiciliary, rest home (e.g., boarding home), or custodial care and home visits into a single code set.
- Choice of medical decision making or time to select visit level (except for visits that are not timed, such as emergency department visits).
- Eliminated use of history and exam to determine visit level (instead there is a requirement for a medically appropriate history and/or exam).
- New descriptor times (where relevant).
- Revised CPT E/M guidelines for levels of medical decision making.

We are finalizing Medicare-specific coding for prolonged Other E/M services. We are creating three new G codes (one per E/M family) for reporting prolonged hospital inpatient or observation services (G0316), prolonged nursing facility services (G0317), and prolonged home or residence services (G0318). Prolonged cognitive impairment assessment services will be reported using G2212, the Medicare-specific code for prolonged office/outpatient services. CPT codes will not be used to report these services.

Split (or Shared) Visits

We are delaying for another year our CY 2022 final policy defining the substantive portion of a split (or shared) visit as more than half of the total practitioner time. For CY 2023, as in CY 2022, the substantive

portion can be one of the following:

- History;
- Physical exam;
- Medical decision making; or
- More than half of the total practitioner time.

Critical Care

We issued a technical correction clarifying that the reporting threshold time for the add-on code for critical care services, is the same for split (or shared) critical care as for critical care that is not split (or shared). Specifically, CPT code 99292 is used to report additional, complete 30-minute time increments furnished to the same patient, therefore it is not reported until at least 104 minutes are spent (74 + 30 = 104 minutes).

For more information regarding E/M visits, contact Ann Marshall at- (410)-786-3059.

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

For CY 2023, we are modifying our policies to expand coverage of colorectal cancer (CRC) screening in two ways. First, we are modifying coverage and payment requirements for certain CRC screening tests to begin when the individual is 45 years of age or older, including Blood-based Biomarker Tests, The Cologuard™ – Multi-target Stool DNA (sDNA) Test, Immunoassay-based Fecal Occult Blood Test, Guaiac-based Fecal Occult Blood Test, Barium Enema Test and Flexible Sigmoidoscopy Test. Screening Colonoscopy will continue to not have a minimum age limitation. We are not modifying existing maximum age limitations. Second, we are expanding the regulatory definition of CRC screening tests to include a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based CRC screening test returns a positive result. The regulatory definition has been added to 42 CFR 410.37.

See Transmittal 11622/ Change Request 12656 for additional information.

For more information regarding coverage of CRC screening tests, please contact Dan Feller at- (410)-786-6913.

Audiology Services

For CY 2023, CMS is finalizing a policy to allow beneficiaries direct access to an audiologist for certain diagnostic tests for non-acute hearing conditions without an order from a treating physician or NPP, including nurse practitione rs, clinical nurse specialists, and physician assistants. The finalized policy requires the use of a new modifier (AB). This is instead of using HCPCS code GAUDX (that encompassed a list of 36 CPT codes) as we proposed. We were persuaded by the commenters that use of a modifier would improve accuracy (regarding both billing for the services actually performed and CMS' tracking of those services) as well as reducing burden for audiologists. The service(s) billed with modifier AB, alongside any of those on the finalized list of 36 CPT codes, would include those personally furnished by the audiologist on a single treatment day to allow beneficiaries to receive care for non-acute hearing assessments (gradual loss of hearing, typically in both ears) and services related to implanted auditory prosthetic devices (including cochlear, osseointegrated, and auditory brainstem implants) that are unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids. As proposed, we are finalizing to permit audiologists to bill for this direct access (without an order) once every 12 months, per beneficiary, effective January 1, 2023.

The long descriptor for modifier AB is: "Audiology service furnished personally by an audiologist without a physician/npp order for non-acute hearing assessment unrelated to disequilibrium, or hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids; service may be performed once every 12 months, per beneficiary". The permissible use of the AB modifier is delineated as such on the

list of Audiology Services that is found on the MPFS website at: https://www.cms.gov/audiology-services, as follows:

- Is required to be used alongside any of the codes on the finalized list of 36 CPT codes, but only when the beneficiary has directly accessed the audiologist (that is, without a physician/NPP order); although, there will be times that audiologists will bill for these services, as appropriate, when the beneficiary presents with an order/referral from a physician/NPP that will not have the modifier appended.
- Is not applicable to the remainder of the codes on the Audiology Services code list ─ 14 CPT codes for vestibular function tests – for which codes billed with the AB modifier will be rendered unpayable.

For each beneficiary, only one visit to an audiologist without a physician/NPP order is permitted every 12 months. That is, the audiologist may bill using modifier AB once every 12 months – regardless of the number of applicable CPT codes billed with the modifier on that date of service. For example, if one CPT code is billed with the AB modifier on a certain date, none of the codes on the list of 36 applicable CPT codes will be payable under the PFS for another 12 months without a qualifying order.

For more information regarding audiology services, please call Pamela West at- (410)-786-2302

Behavioral health

To reduce barriers to beneficiaries' access to needed behavioral health services, for CY 2023 CMS is finalizing a proposal to amend regulations at § 410.26(b)(5) to allow behavioral health services to be furnished under the general supervision of a physician or NPP when these services or supplies are provided by auxiliary personnel incident to the services of a physician or NPP. Additionally, in response to feedback we have received and considering the increased needs for mental health services, CMS is finalizing a proposal to create a new HCPCS code (G0323) describing General Behavioral Health Integration performed by clinical psychologists (CP) or clinical social workers (CSW) to account for monthly care integration where the mental health services furnished by a CP or CSW are serving as the focal point of care integration.

Chronic pain management

In the CY 2022 PFS proposed rule, CMS explored refinements to the PFS that would appropriately value chronic pain management and treatment (CPM) by soliciting comment on CPM for the purpose of future rulemaking. CMS is finalizing a CY 2023 proposal to create two new G codes (G3002 and G3003) performed by physicians and other qualified health professionals, describing monthly CPM for payment beginning January 1, 2023.

For more information regarding Behavioral health and Chronic pain management, please call Erick Carrera at- (410)-786-8949.

Opioid Treatment Programs (OTPs)

To stabilize the price for methadone for CY 2023 and subsequent years, we are finalizing our proposal to revise our methodology for pricing the drug component of the methadone weekly bundle and the add-on code for take-home supplies of methadone. As proposed, we will base the payment amount for the drug component of HCPCS codes G2067 and G2078 for CY 2023 and subsequent years on the payment amount for methadone in CY 2021 and update this amount annually to account for inflation using the PPI for Pharmaceuticals for Human Use (Prescription). Additionally, based on the severity of needs of the patient population diagnosed with opioid use disorder (OUD) and receiving services in the OTP setting, we are finalizing our proposal to modify the payment rate for the non-drug component of the bundled payments for episodes of care to base the rate for individual therapy on a crosswalk code describing a 45-minute session, rather than the current crosswalk to a code describing a 30-minute session. This will increase overall

payments for medication-assisted treatment and other treatments for OUD, recognizing the longer therapy sessions that are usually required.

We are also finalizing our proposal to allow the OTP intake add-on code to be furnished via two-way audio-video communications technology when billed for the initiation of treatment with buprenorphine, to the extent that the use of audio-video telecommunications technology to initiate treatment with buprenorphine is authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) at the time the service is furnished. We are also finalizing our proposal to permit the use of audio-only communication technology to initiate treatment with buprenorphine in cases where audio-video technology is not available to the beneficiary and all other applicable requirements are met. Additionally, we are finalizing allowing periodic assessments to be furnished audio-only when video is not available for the duration of CY 2023, to the extent that it is authorized by SAMSHA and DEA at the time the service is furnished.

Additionally, we are clarifying that OTPs can bill Medicare for medically reasonable and necessary services furnished via mobile units in accordance with SAMHSA and DEA guidance. We are finalizing our proposal that locality adjustments for services furnished via mobile units would be applied as if the service were furnished at the physical location of the OTP registered with DEA and certified by SAMHSA.

For more information regarding OTPs, please contact Lindsey Baldwin at- (410)-786-1694

Dental and Oral Health Services

Medicare currently pays for dental services in a limited number of circumstances, such as when that service is an integral part of specific treatment of a beneficiary's primary medical condition. Some examples include reconstruction of the jaw following accidental injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation. We proposed to clarify and codify certain aspects of our current Medicare Fee For Service (FFS) payment policies for dental services. We also proposed and sought comment on payment for other dental services, such as dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures that may be inextricably linked to, and substantially related and integral to, the clinical success of an otherwise covered medical service. Effective for CY 2023, we are finalizing both policies as proposed and are also finalizing a process to review public submissions of other potentially analogous medical services where dental services are inextricably linked. Lastly, beginning in CY 2024, we are finalizing Medicare FFS payment for dental services, such as dental exams and necessary treatments prior to the treatment for head and neck cancers. CMS will issue forthcoming instructions regarding the implementation of this policy.

For more information regarding dental and oral health services, please contact Emily Forrest at- 410-786-8011.

Skin Substitutes

We proposed several changes to the policies for skin substitute products to streamline the coding, billing, and payment rules and to establish consistency with these products across the various settings. Specifically, we proposed to change the terminology of skin substitutes to 'wound care management products', and to treat and pay for these products as incident to supplies under the MPFS beginning on January 1, 2024. After reviewing comments on the proposals, we understand that it would be beneficial to provide interested parties more opportunity to comment on the specific details of changes in terminology, coding, and payment mechanisms prior to finalizing a specific date when the transition to more appropriate and consistent payment and coding for these products will be completed. We plan to conduct a Town Hall in early CY 2023 with interested parties to address commenters' concerns as well as discuss potential approaches to the methodology for payment of skin substitute products under the MPFS. We will take into account the comments we received in response to CY 2023 rulemaking and feedback received in association with the

Town Hall in order to strengthen proposed policies for skin substitutes in future rulemaking.

For more information regarding skin substitutes, please contact Geri Mondowney at- (410)-786-1172.

FY modifier reduction changes from 7 Percent to 10 Percent

As required by Medicare law, effective January 1, 2018, a payment reduction of 7 percent applies to imaging services that are X-rays taken using computed radiography (including the X-ray component of a packaged service). The payment reduction increases to 10 percent in 2023 and subsequent years.

(See CR 10188 for more information.)

II. BUSINESS REQUIREMENTS TABLE

"Shall" denotes a mandatory requirement, and "should" denotes an optional requirement.

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12982.1	Contractors shall be aware of the policies published in the Medicare Physician Fee Schedule Final Rule (Regulation number CMS-1770-F, Medicare and Medicaid Programs; CY 2023 Payment Policies Under the Physician Fee Schedule and Other Changes to Part B Payment Policies; Medicare Shared Savings Program Requirements; Medicare and Medicaid Provider Enrollment Policies, Including for Skilled Nursing Facilities; Conditions of Payment for Suppliers of Durable Medicaid Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS); and Implementing Requirements for Manufacturers of Certain Single-Dose Container or Single-Use Package Drugs To Provide Refunds With Respect to Discarded Amounts), which are summarized with this change request and apply those policies as appropriate.	X	X	X						
12982.2	Contractors shall continue to pay for the Medicare telehealth originating site facility fee as 80 percent of, the lesser of the actual charge or $28.64, as described by HCPCS code Q3014 "Telehealth facility fee," effective for dates of service on and after January 1, 2023.	X	X	X						
12982.3	Contractors shall use the list of telehealth services found on the CMS website at http://www.cms.gov/Medicare/Medicare-General-Information/Telehealth/Telehealth-Codes.	X	X							

Number	Requirement	Responsibility								
		A/B MAC			DME MAC	Shared-System Maintainers				Other
		A	B	HHH		FISS	MCS	VMS	CWF	
12982.4	Contractors shall use the list of codes that are subject to the CT modifier reduction found on the CMS website at https://www.cms.gov/medicare/physician-fee-schedule/ct-modifier-reduction-list.		X							
12982.5	Contractors shall use the prolonged preventive services G0513 and G0514 as an add-on to the covered preventive services located on the CMS website at https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/Medicare-PFS-Preventive-Services.html.		X							

III. PROVIDER EDUCATION TABLE

Number	Requirement	Responsibility				
		A/B MAC			DME MAC	CEDI
		A	B	HHH		
12982.6	Medicare Learning Network® (MLN): CMS will market provider education content through the MLN Connects® newsletter shortly after CMS releases the CR. MACs shall follow IOM Pub. No. 100-09 Chapter 6, Section 50.2.4.1 instructions for distributing the MLN Connects newsletter information to providers and link to relevant information on your website. You may supplement MLN content with your local information after we release the MLN Connects newsletter. Subscribe to the "MLN Connects" listserv to get MLN content notifications. You don't need to separately track and report MLN content releases when you distribute MLN Connects newsletter content per the manual section referenced above.	X	X	X		

IV. SUPPORTING INFORMATION

Section A: Recommendations and supporting information associated with listed requirements: N/A

"Should" denotes a recommendation.

X-Ref Requirement Number	Recommendations or other supporting information:

Section B: All other recommendations and supporting information: N/A

V. CONTACTS

Pre-Implementation Contact(s): Kathleen Kersell, 410 786-2033 or Kathleen.Kersell@cms.hhs.gov , Julie Rauch, 410-786-8932 or julie.rauch@cms.hhs.gov

Post-Implementation Contact(s): Contact your Contracting Officer's Representative (COR).

VI. FUNDING

Section A: For Medicare Administrative Contractors (MACs):
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ATTACHMENTS: 0