



Medicare Physician Fee Schedule Final Rule Summary: CY 2023

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Related CR Title: 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

Provider Types Affected

This MLN Matters Article is for physicians, providers and suppliers submitting claims to Medicare Administrative Contractors (MACs) for services they provide to Medicare patients.

Provider Action Needed

Make sure your billing staff knows about the following CY 2023 MPFS updates:

- Telehealth originating site facility fee payment amount
- Expansion of coverage for colorectal cancer screening
- Coverage of Audiology services
- Other covered services

Background

This Article gives a summary of the policies in the CY 2023 MPFS. CMS issued the [2023 Physician Fee Schedule](#) final rule updating payment policies and Medicare payment rates for services we pay providers under the MPFS in CY 2023. The final rule also addresses public comments on Medicare payment policies proposed earlier this year. We summarize the payment policies under the MPFS in CY 2023 in this Article.

Medicare Telehealth Services

For CY 2023, we're adding new HCPCS codes to the list of Medicare telehealth services on a Category 1 basis, specifically HCPCS codes G0316, G0317, G0318, G3002, and G3003. We're keeping many services that are temporarily available as telehealth services for the duration of

the COVID-19 Public Health Emergency (PHE) on a Category 3 basis through CY 2023; including: 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’re extending the time services are temporarily included on the Medicare Telehealth Services List during the PHE, but aren’t 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’re implementing the 151-day extensions of Medicare telehealth flexibilities in the CAA, 2022, including allowing telehealth services to be provided in any geographic area and in any originating site setting, including the patient’s home, allowing certain services to be provided via audio-only telehealth, and allowing physical therapists, occupational therapists, speech-language pathologists, and audiologists to provide telehealth services. The CAA, 2022 also delays the in-person visit requirements for mental health services you provide via telehealth until 152 days after the end of the PHE.

For 2023, you should continue billing telehealth claims with the place of service indicator you would bill for an in-person visit. You must use modifier 95 to identify them as telehealth services through the end of CY 2023 or the end of the year in which the PHE ends. See [list of codes added to the telehealth services list](#).

Telehealth Origination Site Facility Fee Payment Amount Update

The payment amount for HCPCS code Q3014 (Telehealth originating site facility fee) is 80% of the lesser of the actual charge, or \$28.64 for CY 2023 services. We base this on the percentage increase in the Medicare Economic Index (MEI) as defined in Section 1842(i)(3) of the [Social Security Act](#). The 2023 MEI increase is 3.8%. The patient is responsible for any unmet deductible amount and Medicare coinsurance.

Evaluation and Management (E/M) Visits

For CY 2023, we’re 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’re 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 (for example, 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 aren't timed, such as emergency department visits).
- Eliminated use of history and exam to decide visit level (instead, there's a requirement for a medically appropriate history or exam or both).
- New descriptor times (where relevant).
- Revised CPT E/M guidelines for levels of medical decision making.

We're finalizing Medicare-specific coding for prolonged Other E/M services and creating 3 new G codes (one per E/M family). These are:

- G0316 for reporting prolonged hospital inpatient or observation services
- G0317 for prolonged nursing facility services
- G0318 for prolonged home or residence services

Report prolonged cognitive impairment assessment services using G2212, the Medicare-specific code for prolonged office/outpatient services. Don't use CPT codes to report these services.

Split (or Shared) Visits

We're 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 1 of the following:

- History
- Physical exam
- Medical decision making
- 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 isn't split (or shared). Use CPT Code 99292 to report additional, complete 30-minute time increments provided to the same patient, therefore it isn't reported until at least 104 minutes are spent ($74 + 30 = 104$ minutes).

Expansion of Coverage for Colorectal Cancer Screening and Reducing Barriers

For CY 2023, we're modifying our policies to expand coverage of colorectal cancer (CRC) screening in 2 ways:

- First, we're modifying coverage and payment requirements for certain CRC screening tests to start 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 (iFOBT), Guaiac-based Fecal Occult Blood Test (gFOBT),

Barium Enema Test, and Flexible Sigmoidoscopy Test. Screening Colonoscopy will continue with no minimum age limitation. We aren't modifying existing maximum age limitations.

- Second, we're 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. We added the regulatory definition to [42 CFR 410.37](#).

See MLN Matters Article [MM12656](#) for more information.

Audiology Services

For CY 2023, we're finalizing a policy to allow patients 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 practitioners, clinical nurse specialists, and physician assistants. The finalized policy requires the use of the new AB modifier. This is instead of using HCPCS code GAUDX (that encompassed a list of 36 CPT codes) as we proposed.

Services billed with modifier AB, with any of those on the finalized list of 36 CPT codes, would include those the audiologist personally:

- Provided by the audiologist on a single treatment day to allow patients to get care for non-acute hearing assessments (gradual loss of hearing, typically in both ears)
- Related to implanted auditory prosthetic devices (including cochlear, osseointegrated, and auditory brainstem implants) unrelated to disequilibrium, hearing aids, or examinations for the purpose of prescribing, fitting, or changing hearing aids.

As proposed, we're finalizing to permit audiologists to bill for this direct access (without an order) once every 12 months, per patient, effective January 1, 2023.

We show the permissible use of the AB modifier on the list of Audiology Services on the [PFS website](#), as follows:

- Must be used alongside any of the codes on the finalized list of 36 CPT codes, but only when the patient has directly accessed the audiologist (that's, without a physician or NPP order). Although there'll be times that audiologists will bill for these services, as appropriate, when the patient presents with an order/referral from a physician or NPP that won't have the modifier appended.
- Isn't 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 won't be payable.

For each patient, we allow only 1 visit to an audiologist without a physician or NPP order every 12 months. Audiologists 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 you bill 1 CPT code 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.

Behavioral Health

We're 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 provided by a CP or CSW are serving as the focal point of care integration.

Chronic Pain Management

We're finalizing a CY 2023 proposal to create 2 new G codes (G3002 and G3003) performed by physicians and other qualified health professionals, describing monthly CPM for payment starting January 1, 2023.

Opioid Treatment Programs (OTPs)

To stabilize methadone pricing for CY 2023 and subsequent years, we're finalizing our proposal to revise our method for pricing the drug component of the methadone weekly bundle and the add-on code for take-home supplies of methadone. As proposed, we'll 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 Producer Price Index for Pharmaceuticals for Human Use (Prescription).

Also, based on the severity of needs of the patient population diagnosed with opioid use disorder (OUD) and getting services in the OTP setting, we're finalizing our proposal to modify the payment rate for the non-drug component of the bundled payments for episodes of care. We're basing 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're also finalizing our proposal to allow the OTP intake add-on code you provide via 2-way, interactive, audio-video technology when you bill for the initiation of treatment with buprenorphine using audio-video technology to start treatment with buprenorphine as authorized by the Drug Enforcement Administration (DEA) and Substance Abuse and Mental Health Services Administration (SAMHSA) at the time you provide the service. We're also finalizing our proposal to permit the use of 2-way, interactive, audio-only technology to start treatment with buprenorphine in cases where audio-video technology isn't available to the patient and all other applicable requirements are met.

Also in CY 2023, we're:

- Allowing you to provide periodic assessments with audio-only when video isn't available for the duration of CY 2023, when SAMHSA and DEA authorizes it at the time you provide the service.
- Clarifying that OTPs can bill Medicare for medically reasonable and necessary services provided via mobile units in accordance with SAMHSA and DEA guidance. We'll apply locality adjustments for services you provide via mobile units as if you provided the service at the physical location of the OTP registered with DEA and certified by SAMHSA.

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 patient'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
- 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 the clinical success of an otherwise covered medical service.

Effective for CY 2023, we're finalizing both policies as proposed and finalizing a process to review public submissions of other potentially analogous medical services where dental services are inextricably linked. Lastly, starting in CY 2024, we're finalizing Medicare FFS payment for dental services, such as dental exams and necessary treatments prior to the treatment for head and neck cancers.

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 starting on January 1, 2024. 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 method for payment of skin substitute products under the MPFS.

FY Modifier Reduction Changes from 7% to 10%

As required by Medicare law, effective January 1, 2018, a payment reduction of 7% 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% in 2023 and subsequent years. (See [CR 10188](#) for more information.)

More Information

We issued [CR 12982](#) to your MAC as the official instruction for this change.

For more information, [find your MAC's website](#).

Document History

Date of Change	Description
November 17, 2022	Initial article released.

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