

2023 Medicare Physician Fee Schedule Proposed Rule

Overview

On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) released the CY 2023 Revisions to Payment Policies under the Medicare Physician Fee Schedule (MPFS) and Other Changes to Part B Payment Policies [CMS-1770-P] [Proposed Rule](#). CMS shows the impact of the provisions of the rule to be a zero percent change for neurosurgery. However, CMS proposes a CY 2023 conversion factor (CF) of 33.0775, which is a 4.42 percent (rounded to 4.5%) reduction relative to the CY 2022 CF of 34.6062, which comes in addition to the pending 4% pay-as-you-go cut that Congress postponed last year and the resumption of the 2% annual Medicare payment sequester.

Reimbursement Issues

CMS Review of RUC-passed Neurosurgery Codes

Below is a list of new codes presented to the AMA/Specialty Society RVS Update Committee (RUC) by the AANS and the CNS showing the RUC-passed work relative values (wRVUs) and, in many cases, the lower CMS proposed wRVUs. Neurosurgery and the AMA RUC will dispute these changes in our comment letters.

CPT Code	Descriptor	RUC-passed wRVU	Proposed wRVU
22630	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; lumbar	15.95	14.91
22632	Arthrodesis, posterior interbody technique, including laminectomy and/or discectomy to prepare interspace (other than for decompression), single interspace; each additional interspace	5.22	5.22
22633	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; lumbar	26.80	24.83
22634	Arthrodesis, combined posterior or posterolateral technique with posterior interbody technique including laminectomy and/or discectomy sufficient to prepare interspace (other than for decompression), single interspace; each additional interspace and segment	7.96	7.30

CPT Code	Descriptor	RUC-passed wRVU	Proposed wRVU
22857	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); single interspace, lumbar	27.13	27.13
22869	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; single level	7.03	7.03
22870	Insertion of interlaminar/interspinous process stabilization/distraction device, without open decompression or fusion, including image guidance when performed, lumbar; second level	2.34	2.34
228XX	Total disc arthroplasty (artificial disc), anterior approach, including discectomy to prepare interspace (other than for decompression); second interspace, lumbar (List separately in addition to code for primary procedure)	Carrier-priced	Carrier-priced
63020	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, cervical	15.95	14.91
63030	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; 1 interspace, lumbar	13.18	12.00
63035	Laminotomy (hemilaminectomy), with decompression of nerve root(s), including partial facetectomy, foraminotomy and/or excision of herniated intervertebral disc; each additional interspace, cervical or lumbar	4.00	3.86
63052	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; single vertebral segment	5.70	4.25
63053	Laminectomy, facetectomy, or foraminotomy (unilateral or bilateral with decompression of spinal cord, cauda equina and/or nerve root[s] [eg, spinal or lateral recess stenosis]), during posterior interbody arthrodesis, lumbar; each additional segment	5.00	3.78

Potentially Misvalued Codes — CPT Code 23091

CMS received a request to designate CPT code 23091 Allograft, structural, for spine surgery only (List separately in addition to code for primary procedure) as potentially misvalued. CMS has disagreed with the rationale provided by the requester and is proposing not to designate the procedure as misvalued.

Medicare Economic Index (MEI)

CMS is considering proposals to rebase and revise the Medicare Economic Index (MEI) cost share weights, and the agency is soliciting comments on this issue. The MEI measures the input prices for providing physician services. The agency proposes a new methodology that allows data to reflect better current market conditions for both “physician ownership practices” and self-employed physicians. It will also enable the MEI to be updated more frequently. The change would not impact the overall MPFS spending but could result in significant changes to payment for particular specialties. CMS is not proposing to use the updated MEI data to set payment rates for CY 2023 but is soliciting comments on future use.

According to the analysis in the proposed rule, the estimated impact on neurosurgery if CMS were to use the proposed rebased and revised MEI cost share weights to adjust the RVUs **would be an 8 percent decrease in total allowed charges**. The AANS and the CNS will submit comments on this plan.

Practice Expense (PE)

CMS proposes several changes to the practice expenses component of the MPFS.

- **CMS Changes to Direct PE Inputs for Neurosurgery Codes.** CMS is proposing to remove 125 minutes of equipment time for an exam light for spine CPT codes 63020 and 63030 because the RUC contested the typicality of its use to assess the wound and remove staples. However, this is standard equipment in neurosurgical and orthopaedic exam rooms. In our comments, the AANS and the CNS will justify these costs and urge CMS not to remove the equipment time.
- **Clinical Labor Update.** CY 2022 was the final year of a multi-year phased update for practice expense (PE) for supplies and equipment and the first year of a four-year phase-in to update to PE clinical labor pricing, as previous data for this component was nearly 20 years old. FY 2023 will be the second of the four years for the phased-in update, and CMS is soliciting comments on any concerns about the implementation process.

Global Surgical Services

CMS seeks public comment on strategies for “improving” global surgery code values, continuing to assert that RVUs for these services are inaccurate. The agency has rehashed its comments on the issue and cited questionable data from the flawed RAND studies.

The AANS and the CNS will push CMS to immediately increase all the global codes to reflect the updated stand-alone evaluation and management (E/M) code values. Organized surgery believes that the RUC process should be used to revalue any global codes that CMS believes may be overvalued. Since the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA) in 2015— which called on CMS to review global surgery code values — more than 150-200 new and revised codes have gone through the RUC, which has also evaluated the post-op values of these codes as necessary. The surgical community has written CMS multiple letters, including a thorough technical analysis of the issues, and CMS has never responded.

Evaluation and Management Issues

As part of the ongoing updates to E/M visits and related coding guidelines, CMS will adopt the substantial portion of the AMA CPT Editorial Panel-approved revised coding and updated guidelines for other E/M visits. This includes inpatient, observation, emergency department, nursing facility and home/residence service visits.

In a positive development, CMS is postponing its proposal for “split or shared” E/M visits, defined as visits provided in a facility by a physician and a non-physician provider in the same group. Last year,

CMS implemented a condition that only the practitioner who provides the substantive portion by time of the visit would be able to bill for the visit. The AANS and the CNS had opposed the restriction. The rule proposes to delay until 2024 the change and clinicians who furnish split (or shared) visits will continue to have a choice of history, physical exam, medical decision making or time spent to define the substantive portion, instead of using only total time to determine the substantive portion.

National Coverage Determination Change for Ambulatory EEG Monitoring

As part of an initiative begun in 2021 to sunset outdated National Coverage Determinations (NCDs), CMS has proposed discontinuing the NCD for Ambulatory Electroencephalographic Monitoring and has asked for public comment on the issue.

Expansion of Telehealth

CMS is considering several policy changes related to telehealth.

- **Neurostimulator Pulse Generator/Transmitter (CPT codes 95976, 95977, 95970, 95983, 95984).**
CMS considered the following codes for possible telehealth status:
 - + **Analysis of cranial nerve neurostimulation (CPT codes 95976 and 95977).** CMS is not proposing to add these codes to the Medicare Telehealth Services List because the full scope of service elements described by these codes cannot currently be furnished via two-way, audio-video communication technology. However, for potential future rulemaking, CMS will consider additional evidence regarding the ability to provide these services via telehealth, such as information indicating that current technology has evolved.
 - + **General brain nerve neurostimulation (CPT codes 95970, 95983, 95984).** CMS proposes to add these codes to the Medicare Telehealth Services List on a Category 3 basis while soliciting comments on concerns regarding patient safety and whether the services are appropriate for inclusion outside the circumstances of the public health emergency (PHE).
- **Telehealth Transition after PHE.** CMS proposes to implement the telehealth provisions in the Consolidated Appropriations Act, 2022 (CAA, 2022) to ensure a smooth transition after the PHE ends. These policies extend certain flexibilities in place during the PHE for 151 days after the PHE ends, allowing:
 - + Payment for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for furnishing telehealth services under the payment methodology established for the PHE;
 - + Telehealth services to be furnished in any geographic area and any originating site setting, including the beneficiary's home; and
 - + Certain services to be furnished via audio-only telecommunications systems.

The CAA, 2022 also delays the in-person visit requirements for mental health visits furnished by RHCs and FQHCs via telecommunications technology until 152 days after the end of the PHE.

Quality Provisions

CMS proposes relatively few changes to the Quality Payment Program (QPP) for 2023.

The 2023 Merit-Based Incentive Payment System (MIPS) performance category weights will remain:

- 30% Quality;
- 30% Cost;
- 15% Improvement Activities; and
- 25% Promoting Interoperability.

CMS proposes maintaining the current MIPS performance threshold of 75 points in 2023 to avoid potential penalties of up to 9% in 2025. CMS also intends to move ahead with MIPS Value Pathways

(MVPs), which will offer clinicians an alternative participation pathway starting in 2023, which the agency believes is more clinically focused and less burdensome. New MVPs proposed for 2023 include:

- Optimal Care for Patients with Episodic Neurological Conditions (focusing on epilepsy and headache; and
- Supportive Care for Neurodegenerative Conditions (focusing on dementia, Parkinson’s and ALS).

For clinicians who opt to participate through traditional MIPS, CMS proposes to add a new Screening for Social Drivers of Health measure and remove multiple neurosurgical-focused measures, including:

- #260: Rate of CEA for Asymptomatic Patient;
- #460: Back Pain After Lumbar Fusion;
- #469: Functional Status After Lumbar Fusion; and
- #473: Leg Pain After Lumbar Fusion.

CMS also proposes to require the “Query of the Prescription Drug Monitoring Program (PDMP)” measure under the Promoting Interoperability category, which the AANS and the CNS have previously opposed. Finally, CMS includes numerous requests for information related to the following:

- Advancement of digital quality measurement;
- Accounting for health equity in quality measurement and public reporting;
- Patient access to health information; and
- Examining QPP incentives in light of the expiring 5% alternative payment model incentive payment in 2023.

More Information

The AANS and the CNS are reviewing the proposal and will submit comments before the Sept. 6 deadline. More details on the proposed rule are available in a CMS [press release](#) (with links to multiple fact sheets).

Additional questions can be directed to AANS/CNS Washington Office staff:

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