CMS Proposed Rule:
2023 Medicare Physician Fee Schedule
ASAM Summary of Major Provisions

On November 1, 2022 the Centers for Medicare and Medicaid Services (CMS) issued a final rule which revises CY 2023 payment policies under the Medicare Physician Fee Schedule (PFS) and makes other policy changes.

CMS has also published a fact sheet on the 2023 Medicare Physician Fee Schedule Final Rule, available here.

A summary of the major changes is listed below:

Conversion Factor

CMS finalized a CY 2023 Medicare conversion factor (CF) of $33.06, a decrease of $1.55 from the 2022 CF rate of $34.6062. The final CF is largely a result of an expiring 3 percent increase funded to the CF at the end of CY 2022 as required by law. The additional approximate 1.5 percent decrease to the CF is a result of a budget neutrality adjustment primarily from increases to payment for hospital, nursing facility, home health and emergency medicine visits.

Telehealth

During the COVID-19 Public Health Emergency (PHE), CMS significantly expanded the Medicare Telehealth List through the addition of about 150 services that can now be provided via telehealth, including emergency department visits, critical care, home visits, and telephone visits. It also created two new categories of interim telehealth services. Codes in Category 3 of the Medicare Telehealth List are covered on an interim basis until data can be gathered to help determine whether they should become Category 1 or 2 services or be removed from telehealth coverage. Category 3 services will be covered through the end of 2023. Interim services that are not in Category 3 were only slated to be covered until the end of the PHE. In March 2022, the Consolidated Appropriations Act included a provision that extended payment for Medicare telehealth services to all communities in the country, not just rural areas, and allowed patients to continue to receive telehealth services in their homes or wherever they are located without going to a medical facility for an additional 151 days after the end of PHE, which is five months. In an earlier proposal, CMS proposed to similarly extend Medicare telehealth coverage for the codes that were only going to be on the telehealth list through the end of the PHE for an additional five months after the PHE ends. CMS adopted this proposal in its final rule and services included temporarily on the list of telehealth services on an interim basis will now be covered for 151 days after the end of the PHE. CMS also finalized a delay of the in-person visit requirements for mental health services (including substance use disorder) furnished via telehealth until 152 days after the end of the PHE, inline with the Consolidated Appropriations Act of 2022.

Additionally, CMS received requests to add the telephone evaluation and management (E/M) codes to the list of covered telehealth services on a category three basis. CMS noted in the final rule that the agency was declining to add these services on a category 3 basis, noting that while audio-only services will remain appropriate to bill for delivery of mental health services given the change in the telehealth definition made by regulation last year, statute requires that telehealth services be so analogous to in-person care such that the telehealth service is essentially a substitute for a face to-

face encounter. In the final rule, CMS again stated that it would not add telephone E/M codes to the list of telehealth services. CMS provided that due to a change in the definition of "telecommunications system" during 2022 rulemaking allowing telehealth services for the diagnosis, evaluation, and treatment of mental health conditions (including substance use disorder) to be furnished through audio-only technology in certain circumstances, the agency did not believe it was appropriate or necessary to add these codes to the list of telehealth services.

CMS also finalized certain changes in coding and payment policies that would take effect five months after the PHE ends. Most importantly, Medicare telehealth services will revert to being paid at the "facility" rate instead of the "non-facility" rate, as CMS believes that the facility payment amount "best reflects the practice expenses, both direct and indirect, involved in furnishing services via telehealth." CMS finalized this proposal.

Medicare Coverage for Opioid Use Disorder (OUD) Treatment Services Furnished by Opioid Treatment Programs (OTPs)

Methadone Price

CMS is finalizing an earlier proposal that beginning in calendar year (CY) 2023 and for subsequent years, the payment amount for methadone will be based on the payment amount for methadone in CY 2021 as determined under § 410.67(d)(2)(i)(B)(1) and updated by the Produce Price Index (PPI) for Pharmaceuticals for Human Use (Prescription). The 2023 price for the drug component of the OTP bundle for methadone will be $39.29, a roughly $2 increase from the current rate.

OTP Bundle - Therapy

Currently, the individual therapy component of the OTP bundles is priced based on a crosswalk to CPT code 90832 (Psychotherapy, 30 minutes with patient). CMS has received feedback that patients with OUD are often utilizing more individual therapy than the current 30 minute crosswalk suggests. Therefore, CMS finalized a proposal to modify the payment rate for the non-drug component of the bundled payment for an episode of care to base the rate for individual therapy on a crosswalk to CPT code 90834 (Psychotherapy, 45 minutes with patient).

Beginning with CY 2023, CMS would apply the Medicare Economic Index (MEI) from 2021-23 to update the 2023 payment rate for the non-drug components of the bundle.

CMS also clarified that practitioners can bill for OTP bundled services even if the duration of a therapy session is less than 45 minutes, noting that "This crosswalk code is being used for the purposes of valuation, but we do not intend it to be a requirement regarding the number of minutes spent in an individual therapy session in order for the service to qualify as an OUD treatment service."

G2076 – OTP Intake Activities

CMS finalized a proposal to allow G2076 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 DEA and SAMHSA at the time the service is furnished. CMS also finalized its 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. CMS interprets the requirement that audio/video technology is "not available to the beneficiary" to include circumstances in which the beneficiary is not capable of or has not consented to the use of devices that permit a two-way, audio/video interaction.

G2077

CMS sought comment on whether to allow periodic assessments (G2077) to continue to be furnished using audio-only communication technology following the end of the PHE for COVID-19 for patients who are receiving treatment via buprenorphine, and if this flexibility should also continue to apply to patients receiving methadone or naltrexone. Prior to the declaration of the PHE, the CY 2021 PFS Final Rule amended the definition of periodic assessment in Section 410.67(b)(7) to say that the definition is limited to a face-to-face encounter, and that a clinician must perform a face-to-face medical exam or biopsychosocial assessment to bill G2077. In 2023, CMS has finalized regulations that will allow G2077 to be furnished using audio-only communication technology following the end of the PHE for COVID-19 for patients who are receiving treatment via buprenorphine. CMS notes in the final rule that it will continue to evaluate whether to extend this flexibility to patients treated with naltrexone and methadone.

Mobile Units

CMS finalized policy clarifying that OTPs can bill Medicare for medically reasonable and necessary services furnished via mobile units in accordance with SAMHSA and DEA guidance. The agency also finalized a proposal allowing locality adjustments for services furnished via mobile units to be applied as if the service were furnished at the physical location of the OTP registered with DEA and certified by SAMHSA.

Requirement for Electronic Prescribing for Controlled Substances (EPCS)

CMS is finalizing a proposal to extend the existing non-compliance action of sending letters to non-compliant prescribers for the EPCS program from 2023 into 2024. These letters would consist of a notification to prescribers that they are violating the EPCS requirement, information about how they can come into compliance, the benefits of EPCS, an information solicitation as to why they are not conducting EPCS, and a link to the CMS portal to request a waiver. CMS will utilize email addresses as the primary method of contacting prescribers.

While CMS noted in it proposed rule that the agency plans to increase the severity of penalties beginning in CY 2025, CMS added in the final rule that it continues to consider potential penalties and therefore does not intend to finalize any additional penalties at this time. Below is a list of potential penalties that CMS included in the earlier proposed rule for non-compliant prescribers beginning in CY 2025:

- Requiring a non-compliant prescriber to enter into a corrective action plan, which would require the non-compliant prescriber to comply with the EPCS requirement within 2 years prior to applying other potential actions outlined below;
- Posting a non-compliant prescriber's name on the CMS website and identifying the prescriber as non-compliant;
- Public reporting of EPCS compliance status, including that a prescriber is noncompliant, on the Care Compare website;
- Referral of non-compliant prescribers to the DEA to support potential investigations;
- Sharing the list of EPCS non-compliant prescribers with the States; and/or
- Referral for potential fraud, waste and abuse review.

Annual Alcohol Misuse and Depression Screenings

CMS finalized a proposal to revise the code descriptors for G0442 and G0444 from 15 min to 5-15 minutes following feedback that the 15-minute threshold in the code descriptors for G0442 and G0444 is too high and limits providers ability to bill the codes. CMS did not respond to ASAM's request that the agency reexamine the payment and coverage policy for these services to ensure that qualified practitioners are eligible to bill for these services and to ensure that the policy was consistent with the latest guidance from the US Preventive Services Task Force (USPSTF).

Chronic Pain Management (CPM) Services

CMS is finalized a proposal to create two bundled codes to describe chronic pain management and treatment. The agency is finalizing its proposal to define chronic pain as "persistent or recurrent pain lasting longer than three months." The code descriptors will read as follows:

- *G3002: Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain-related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. Required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (When using G3002, 30 minutes must be met or exceeded.)*

- *G3003: (Each additional 15 minutes of chronic pain management and treatment by a physician or other qualified health care professional, per calendar month. (List separately in addition to code for G3002. When using G3003, 15 minutes must be met or exceeded.)*

After seeking comment from interested parties, CMS also finalizing other provisions related to this bundle, including that:

- These codes will not be used to report acute pain;
- The practitioner must see the patient in-person the first time G3002 is billed;
- A physician or other qualified health practitioner may bill HCPCS code G3003, for each additional 15 minutes of care, an unlimited number of times, as medically necessary, per month, after HCPCS code G3002 has been billed;
- CMS is not limiting the types of physician specialties, or the types of qualified health professionals, who can furnish CPM services, as long as they can furnish all of the service elements of HCPCS code G3002, including prescribing medication as needed, within their scope of practice in the State in which the services are furnished;
- These codes will not be limited to specific places of service, other than that G3003 must be provided in person for the first visit; and
- Any of the CPM in-person components included in HCPCS codes G3002 and G3003 may be furnished via telehealth, as clinically appropriate.

Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)

CMS finalized its proposal to add the CPM and behavioral health integration services to the all inclusive RHC/FQHC payment for general care management (G0511).

CMS also finalized its proposals to implement the telehealth provisions in the Consolidated Appropriations Act, 2022 (CAA, 2022) via program instruction or other sub-regulatory guidance to ensure a smooth transition after the end of the PHE. These policies extend certain flexibilities in place during the PHE for 151 days after the PHE ends, including allowing payment for RHCs and FQHCs for furnishing telehealth services (other than mental health visits that can be furnished virtually on a permanent basis) under the payment methodology established for the PHE. 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.

Supervision Requirements for Behavioral Health Services

CMS finalized its proposal to amend the direct supervision requirement under the agency's "incident to" regulation at § 410.26 to allow behavioral health services to be furnished under the general supervision of a physician or non-physician practitioner (NPP) when these services or supplies are provided by auxiliary personnel incident to the services of a physician or NPP.

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Comment Solicitation on Intensive Outpatient Mental Health Treatment, including Substance Use Disorder (SUD) Treatment, Furnished by Intensive Outpatient Programs (IOPs)

As part of the agency's Behavioral Health Strategy, CMS sought comments on whether or not the current coding and payment mechanisms under the PFS adequately account for intensive outpatient services that are part of a continuum of care in the treatment of substance use disorder. CMS thanked commenters for their responses and indicated that the agency will consider the comments for future rulemaking.