Greater Kansas City MGMA
CMS Webinar: PFS and OPPS Final Rules

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CY 2023 PFS Final Rule Highlights

On November 1, 2022, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes policy changes for Medicare payments under the Physician Fee Schedule (PFS), and other Medicare Part B issues, effective on or after January 1, 2023. Comments on the proposed rule were due by September 6, 2022.

Some of the topics covered in the final rule included:

- CY 2023 PFS Ratesetting and Conversion Factor updates
- Geographic Practice Cost Indices (GPCI) and Malpractice (MP) data update
- Updated Medicare Economic Index (MEI) for CY 2023
- Evaluation and Management Services
- Telehealth and Other Services Involving Communications Technology
- Dental and Oral Health Services
- Behavioral Health Services
- Chronic Pain Management
- Skin Substitutes
- Audiologists
- Colorectal Cancer Screening

Evaluation and Management (E/M) Services – Office/Outpatient (CY 2021)

- For CY 2021, we finalized several policies that took into account the changes to E/M visit codes, as explained in the AMA CPT Codebook, which took effect January 1, 2021.

- We also finalized revaluation of the following code sets that include, rely upon or are analogous to office/outpatient E/M visits commensurate with the increases in values we finalized for office/outpatient E/M visits for CY 2021:
  - End-Stage Renal Disease (ESRD) Monthly Capitation Payment (MCP) Services
  - Transitional Care Management (TCM) Services
  - Maternity Services
  - Cognitive Impairment Assessment and Care Planning
  - Initial Preventive Physical Examination (IPPE) and Initial and Subsequent Annual Wellness Visits (AWV)
  - Emergency Department Visits
  - Therapy Evaluations
  - Psychiatric Diagnostic Evaluations and Psychotherapy Services

- We clarified the definition of HCPCS add-on code G2211 (formerly referred to as GPC1X), previously finalized for office/outpatient E/M visit complexity, and refined our utilization assumptions for this code.

- We also finalized separate payment for a new HCPCS code, G2212, describing prolonged office/outpatient E/M visits to be used in place of CPT code 99417 (formerly referred to as CPT code 99XXX) to clarify the times for which prolonged office/outpatient E/M visits can be reported.

Evaluation and Management (E/M) Services – 'Other E/Ms'

- As part of the ongoing updates to E/M visit codes and related coding guidelines that are intended to reduce administrative burden, the AMA CPT Editorial Panel approved revised coding and updated guidelines for Other E/M visits, effective January 1, 2023.

- Similar to the approach we finalized in the CY 2021 PFS final rule for office/outpatient E/M visit coding and documentation, we finalized and adopted most of these AMA CPT changes in coding and documentation for Other E/M visits (which include hospital inpatient, hospital observation, emergency department, nursing facility, home or residence services, and cognitive impairment assessment) effective January 1, 2023.

- This revised coding and documentation framework includes CPT code definition changes (revisions to the Other E/M code descriptors), including:
    - New descriptor times (where relevant).
    - Revised interpretive guidelines for levels of medical decision making.
    - Choice of medical decision making or time to select code level (except for a few families like emergency department visits and cognitive impairment assessment, which are not timed services).
    - Eliminated use of history and exam to determine code level (instead there would be a requirement for a medically appropriate history and exam).

Evaluation and Management (E/M) Services – 'Other E/Ms' – 2

- **Prolonged Services**
  - Prolonged service codes function like add-on codes, providing additional payment for extended visits per additional time increment.
  - The CPT Editorial Board restructured the prolonged service codes that apply to the Other E/M visit code sets for 2023.
  - We are concerned that the revised CPT prolonged service framework will allow for duplicative or unwarranted billing, pose barriers to oversight, and increase administrative complexity compared to the predecessor codes.
  - Therefore, we finalized creation of Medicare-specific coding for payment of Other E/M prolonged services, similar to what CMS adopted in CY 2021 for payment of Office/Outpatient prolonged services. These services will be reported with three separate Medicare-specific G codes.

Evaluation and Management (E/M) Services – Split (or Shared) Services

- **Split (or Shared) Services**
  - For CY 2023, we finalized a year-long delay of the split (or shared) visits policy we established in rulemaking for 2022. This policy determines which professional should bill for a shared visit by defining the "substantive portion," of the service as more than half of the total time. Therefore, for CY 2023, as in CY 2022, the substantive portion of a visit is comprised of any of the following elements:
    - History
    - Performing a physical exam
    - Making a medical decision
    - Spending time (more than half of the total time spent by the practitioner who bills the visit).
  - As finalized, clinicians who furnish split (or shared) visits will continue to have a choice of history, or physical exam, or medical decision making, or more than half of the total practitioner time spent to define the "substantive portion" instead of using total time to determine the substantive portion, until CY 2024.

Telehealth and Other Services Involving Communications Technology

- For CY 2023, we finalized a number of policies related to Medicare telehealth services under PFS including: making several services that are temporarily available as telehealth services for the PHE, available through 2023 on a Category III basis, to allow additional time for the collection of data that could support their eventual inclusion as permanent additions to the Medicare Telehealth Services list.

- We also finalized our proposal to allow physicians and practitioners to continue to bill with the place of service (POS) indicator that would have been reported had the service been furnished in-person. These claims will require the modifier "95" to identify them as services furnished as telehealth services. Claims can continue to be billed with the place of service code that would be used if the telehealth service had been furnished in-person through the later of the end of CY 2023 or end of the year in which the PHE ends.

Telehealth and Other Services Involving Communications Technology – 2

- **Consolidated Appropriations Act, 2022 (CAA)**
  - We confirmed our intention to implement the telehealth provisions in sections 301 through 305 of the CAA, 2022, via program instruction or other subregulatory guidance to ensure a smooth transition after the end of the PHE. These policies, such as 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, will remain in place during the PHE for 151 days after the PHE ends. 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.

Telehealth and Other Services Involving Communications Technology – 3

- **Virtual Supervision**
  - For the duration of the PHE, to limit infection exposure, we revised the definition of direct supervision to include virtual availability of the supervising physician or practitioner using interactive audio/video real-time communications technology.
  - We will continue this policy through the end of the year in which the PHE ends.
  - In the 2022 and 2023 Final Rules, we solicited comment on whether this revised definition should continue following the PHE, and if so, in what circumstances.

- **Remote Therapeutic Monitoring (RTM)**
  - In the CY 2023 PFS NPRM, we proposed payment for RTM services using four new HCPCS G codes instead of the CPT codes that were previously established. This policy was intended to address coding and billing concerns raised by interested parties.
  - In consideration of the public comments, we finalized a policy to use the existing CPT codes that were created for CY 2022, while we consider the broader RTM landscape, and future RTM related coding.

Dental and Oral Health Services

- Medicare payment for dental services is generally precluded by statute. However, Medicare currently pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a beneficiary's primary medical condition.

- Effective for CY 2023, we 1) finalized our proposal to clarify and codify certain aspects of the current Medicare FFS payment policies for dental services when that service is an integral part of specific treatment of a beneficiary's primary medical condition, and 2) other clinical scenarios under which Medicare Part A and Part B payment can be made for dental services, such as dental exams and necessary treatments prior to, or contemporaneously with, organ transplants, cardiac valve replacements, and valvuloplasty procedures.

- We also finalized payment for dental exams and necessary treatments prior to the treatment for head and neck cancers starting in CY 2024, and finalizing a process in CY 2023 to review and consider public recommendations for Medicare payment for dental service in other potentially analogous clinical scenarios.

- Finally, we are working to address commenters' thoughtful feedback and questions regarding the operational aspects of billing and claims processing for these services.

Behavioral Health Services

- In the 2022 CMS Behavioral Health Strategy, CMS set a goal to improve access to, and quality of, mental health care services.

- In light of the current needs among Medicare beneficiaries for improved access to behavioral health services, we considered regulatory revisions that may help to reduce existing barriers and make greater use of the services of behavioral health professionals, such as licensed professional counselors (LPCs) and Licensed Marriage and Family Therapists (LMFTs). We finalized our proposal to add an exception to the direct supervision requirement under our "incident to" regulation at 42 CFR 410.26 to allow behavioral health services provided under the general supervision of a physician or NPP, rather than under direct supervision, when these services or supplies are provided by auxiliary personnel incident to the services of a physician (or NPP). We believe that this change will facilitate utilization and extend the reach of behavioral health services.

- We also finalized our proposal to create a new General BHI code describing a service personally performed by CPs or clinical social workers (CSWs) 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. Further, we finalized our proposal to allow a psychiatric diagnostic evaluation to serve as the initiating visit for the new general BHI service.

Chronic Pain Management

- We finalized the creation of new HCPCS codes G3002 and G3003 and valuation for chronic pain management and treatment services (CPM) for CY 2023. We believe the CPM HCPCS codes will improve payment accuracy for these services, prompt more practitioners to welcome Medicare beneficiaries with chronic pain into their practices, and encourage practitioners already treating Medicare beneficiaries who have chronic pain to spend the time to help them manage their condition within a trusting, supportive, and ongoing care partnership.

- The finalized codes include a bundle of services furnished during a month that we believe to be the starting point for holistic chronic pain care, aligned with similar bundled services in Medicare, such as those furnished to people with suspected dementia or substance use disorders. We have finalized the CPM codes to include the following elements in the code descriptor:
  - 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 coordination between relevant practitioners furnishing care, such as physical and occupational therapy, complementary and integrative care approaches, and community-based care, as appropriate.

Colorectal Cancer Screening

- For CY 2023, we finalized, two updates to expand our Medicare coverage policies for colorectal cancer screening in order to align with recent United States Preventive Services Task Force and professional society recommendations:
  - We are expanding Medicare coverage for certain colorectal cancer screening tests by reducing the minimum age payment and coverage limitation from 50 to 45 years.
  - We are expanding the regulatory definition of colorectal cancer screening tests to include a complete colorectal cancer screening, where a follow-on screening colonoscopy after a Medicare covered non-invasive stool-based colorectal cancer screening test returns a positive result. A functional outcome of our policy for a complete colorectal cancer screening will be that, for most beneficiaries, cost sharing will not apply for either the initial stool-based test or the follow-on colonoscopy.

- Both of these policies reflect our desire to expand access to quality care and to improve health outcomes for patients through prevention and early detection services, as well as through effective treatments. Our revised colorectal cancer screening policies directly advance our health equity goals by promoting access for much needed cancer prevention and early detection in rural communities and communities of color that are especially impacted by the incidence of colorectal cancer.

- Our policies also directly support President Biden's Cancer Moonshot Goal to cut the death rate from cancer by at least 50 percent over the next 25 years and addresses his recent proclamation of March 2022 as National Colorectal Cancer Awareness Month.

Quality Payment
PROGRAM

OVERVIEW OF THE 2023 QUALITY PAYMENT PROGRAM POLICY UPDATES

Rule Resources

CMS recently issued our policies for QPP via the **CY 2023 PFS Final Rule**.

QPP 2023 Final Rule Resources Zip File Resources:

- **Overview Fact Sheet:** overview of policies for 2023 performance year
- **Policies Comparison Table:** comparison of final 2023 performance year policies to requirements for 2022 performance year
- **MVP Policies Table:** overview of policies for implementation of MVPs beginning in 2023 performance year
- **Frequently Asked Questions (FAQs):** addresses potential questions around rule policies

Reminder: Upcoming Deadlines

- **December 31, 2022** – Virtual group election period for the 2023 performance year closes
- **January 3, 2023** – Promoting Interoperability Hardship Exception and MIPS Extreme and Uncontrollable Circumstances (EUC) Application period closes for the 2022 performance year
- **January 3, 2023** – Data submission opens for the 2022 performance year

Quality Payment Program

Future Direction as Outlined in CY 2023 PFS Final Rule

- We recognize the challenges faced by many across the country over the past 2 years. As we look to the future of QPP, **CMS remains committed to promoting more meaningful participation for clinicians, ensuring the policies continue to drive us toward value and improved health outcomes for patients.**

- **To further these goals under MIPS, the CY 2023 PFS Final Rule focuses on:**
  - Continuing to implement new MVPs
  - Refining the subgroup participation option
  - Refining the quality measure and improvement activities inventories
  - Reducing burden to facilitate participation in APMs

- CMS is proposing limited changes in traditional MIPS to provide clinicians continuity and consistency while they gain familiarity with MVPs.

MIPS Value Pathways (MVPs) Finalized Policies

MVP Participation

- As finalized in the CY 2022 PFS Final Rule, for MIPS 2023, 2024, and 2025 performance years, CMS defines an MVP Participant as:
  - Individual clinicians
  - Single specialty groups
  - Multispecialty groups*
  - Subgroups
  - APM Entities

*Beginning in the 2026 performance year, multispecialty groups will be required to form subgroups to report to MVPs.

For more information about MVP policies, see the CY 2023 PFS Final Rule.

MIPS Value Pathways (MVPs) Finalized Policies

MVP Candidates

CMS is finalizing **5 new MVPs** and revising the **7 previously established MVPs** that would be available beginning with the 2023 performance year:

Newly Finalized MVPs
Advancing Cancer Care MVP
Optimal Care for Kidney Health MVP
Optimal Care for Patients with Episodic Neurological Conditions MVP
Supportive Care for Neurodegenerative Conditions MVP
Promoting Wellness MVP

Previously Established MVPs
Advancing Rheumatology Patient Care MVP
Coordinating Stroke Care To Promote Prevention and Cultivate Positive Outcomes MVP
Advancing Care for Heart Disease MVP
Optimizing Chronic Disease Management MVP
Adopting Best Practices and Promoting Patient Safety within Emergency Medicine MVP
Improving Care for Lower Extremity Joint Repair MVP
Patient Safety and Support of Positive Experiences with Anesthesia MVP

For more information, visit the Explore MVPs webpage.

MIPS Value Pathways (MVPs) Finalized Policies

Subgroups

Subgroup Registration

- Previously finalized that clinicians who choose to participate in a subgroup to report an MVP must register as a subgroup between April 1 and November 30 of the performance year. In addition to the required MVP registration information, the subgroup registration must include:
  - A list of TIN/NPIs in the subgroup,
  - A plain language name for the subgroup (which will be used for public reporting),
- CMS is adding a 3rd required element:
  - A description of the composition of the subgroup, which may be selected from a list or described in a narrative.
- Finalizing that a clinician would only be allowed to register for one subgroup per TIN.

MIPS Value Pathways (MVPs) Finalized Policies

Subgroups

MVP Changes – Subgroup Scoring

For quality and cost measures calculated using administrative claims data, CMS is finalizing to calculate and score these measures for the subgroup at the TIN level (of the affiliate group), not at the subgroup level:

- **Foundational Layer:** For each selected population health measure, subgroups will be assigned the affiliated group's score, if available. In instances where a group score isn't available, each such measure will be excluded from its quality performance category score.
- **Quality Performance Category:** For each selected outcome-based administrative claims measure, subgroups will be assigned the affiliated group's score, if available. In instances where a group score isn't available, each such measure will be assigned zero achievement points.
- **Cost Performance Category:** Subgroups will be assigned the affiliated group's score, if available, for the cost measure(s) included in the subgroup's selected MVP. In instances where a group score isn't available, each such measure will be excluded from the subgroup's cost performance category score.

MIPS Value Pathways (MVPs) Finalized Policies

Subgroups

MVP Changes – Subgroup Final Score

CMS won't assign a final score to a subgroup that registers but doesn't submit data as a subgroup.

2023 MIPS Finalized Policies

Performance Category Weights

Performance Category	Performance Category Weights		
	2023 Traditional MIPS Individuals, Groups, Virtual Groups (no change for 2022)	2023 Traditional MIPS APM Entities (no change for 2022)	2023 APM Performance Pathway (APP) Individuals, Groups, APM Entities (no change for 2022)
 Quality	30%	55%	50%
 Cost	30%	0%	0%
 Improvement Activities	15%	15%	20%
 Promoting Interoperability	25%	30%	30%

CMS is statutorily required to weigh cost and quality equally, beginning with the 2022 performance year.

Note: The APP has different scoring weights compared to APM Entities participating in traditional MIPS.

When an APM Entity reports traditional MIPS, CMS will reweight the quality performance category to 55% according to traditional MIPS performance category reweighting rules, as opposed to 50% under the APP.

2023 MIPS Finalized Policies

Quality Performance Category

Basics:

- Additions, changes, and removals of MIPS quality measures
- Revisions to benchmarks used for 2023 performance year scoring of administrative claims measures
- Updates to data completeness threshold
- Changes to the definition of a high priority measure
- Revisions to the CAHPS for MIPS Survey case-mix adjustment

Data Completeness

2022 Final	2023 Final
• To meet data completeness requirements, data must be reported for at least **70%** of the denominator eligible encounters.	• Maintain data completeness threshold at **70%** for the 2023 performance year. • Increase the data completeness threshold to **75%** for 2024 and 2025 performance years.

Note: The data completeness threshold policies regarding 70% or 75% doesn't apply to CMS Web Interface measures since the CMS Web Interface measures have different data completeness requirements (report on the first 248 consecutively ranked Medicare patients in a sample for a measure or all patients if a sample has less than 248 patients). As a reminder, starting with the 2023 performance period, the CMS Web Interface is only available to Medicare Shared Savings Program Accountable Care Organizations (ACOs) reporting via the APM Performance Pathway (APP).

2023 MIPS Finalized Policies

Promoting Interoperability Performance Category

Basics:

- Discontinue automatic reweighting policy for certain clinician types
- Modify measures and reporting requirements
- Adjust measure points

Reweighting

2022 Final	2023 Final
Automatic reweighting applies to following clinician types: • Nurse practitioners • Physician assistants • Certified registered nurse anesthetists • Clinical nurse specialists • Clinical social workers • Physical therapists • Occupational therapists • Qualified speech-language pathologists • Qualified audiologists • Clinical psychologists, and • Registered dieticians or nutrition professionals Automatic reweighting applies to MIPS eligible clinicians, groups and virtual groups with following special statuses: • Ambulatory Surgical Center (ASC)-based • Hospital-based • Non-patient facing • Small practices	**Discontinuing** automatic reweighting for following clinician types beginning with 2023: • Nurse practitioners • Physician assistants • Certified registered nurse anesthetists • Clinical nurse specialists **Continuing** automatic reweighting for following clinician types in 2023: • Clinical social workers • Physical therapists • Occupational therapists • Qualified speech-language pathologists • Qualified audiologists • Clinical psychologists, and • Registered dieticians or nutrition professionals

2023 MIPS Finalized Policies

Promoting Interoperability Performance Category

Basics:

- Discontinue automatic reweighting policy for certain clinician types
- Modify measures and reporting requirements
- Adjust measure points

Data Submission

2022 Final	2023 Final
When participating in MIPS at the APM Entity level (reporting either the APP or traditional MIPS), Promoting Interoperability data must be reported at the **individual or group level**.	When participating in MIPS at the **APM Entity level,** CMS will allow APM Entities to report Promoting Interoperability data at the APM Entity level. • APM Entities will still have the option to report this performance category at individual and group level.

2023 MIPS Finalized Policies

Promoting Interoperability Performance Category

Basics:

- Discontinue automatic reweighting policy for certain clinician types
- Modify measures and reporting requirements
- Adjust measure points

Public Health and Clinical Data Exchange Objective

2022 Final	2023 Final
There are 3 active engagement options for the measures within this objective: • **Option 1**: Completed Registration to Submit Data • **Option 2**: Testing and Validation • **Option 3**: Production	Modify the levels of active engagement for the Public Health and Clinical Data Exchange Objective measures: • **Combine Options 1 and 2** into a single option titled "Pre-production and Validation" and rename Option 3 to "Validated Data Production" for a total of 2 options. • **Require MIPS eligible clinicians to submit their level of active engagement** in addition to requiring a yes/no response for the required Public Health and Clinical Data Exchange measures. • **Clinicians may spend only one performance period** at the Preproduction and Validation level of active engagement per measure. ◦ They must progress to the Validated Data Production level in the next performance period for which they report. CMS is delaying this requirement until CY 2024.

2023 MIPS Finalized Policies

Promoting Interoperability Performance Category

Basics:

- Discontinue automatic reweighting policy for certain clinician types
- Modify measures and reporting requirements
- Adjust measure points

Query of Prescription Drug Monitoring Program (PDMP) Measure

2022 Final	2023 Final
This is an **optional** measure, worth 10 bonus points in the 2022 performance period.	Making the PDMP measure a **required** measure beginning with the 2023 performance period. • Adding exclusions for the measure and make it worth 10 points. • Expanding the scope of the measure to include not only Schedule II opioids but also Schedules III and IV drugs.

2023 MIPS Finalized Policies

Performance Threshold and Payment Adjustments

2022 Final

Final Score 2022	Payment Adjustment 2024
≥89 points	• Positive adjustment greater than 0% • Eligible for additional payment for exceptional performance—minimum of additional 0.5%
75.01-88.99 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
75 points	• Neutral payment adjustment
18.76-74.99 points	• Negative payment adjustment between -9% and 0%
0-18.75 points	• Negative payment adjustment of -9%

2023 Final

Final Score 2023	Payment Adjustment 2025
75.01-100 points	• Positive adjustment greater than 0% • Not eligible for additional payment for exceptional performance
75 points	• Neutral payment adjustment
18.76-74.99 points	• Negative payment adjustment between -9% and 0%
0-18.75 points	• Negative payment adjustment of -9%

The 2022 performance year/2024 MIPS payment year was the final year for an additional performance threshold/additional MIPS adjustment for exceptional performance.

2023 QPP Public Reporting Finalized Policies

2023 Final

Utilization Data

- Publicly report procedures commonly performed on individual clinician profile pages to aid patients in finding clinicians who may appropriately serve their needs.
  - Add utilization data to profile pages to allow patients to find clinicians who have performed specific types of procedures.

Telehealth Indicators

- Publicly report a telehealth indicator, as applicable and technically feasible, on individual clinician profile pages for those clinicians furnishing covered telehealth services.
  - Add telehealth indicators to clinician profile pages to help to empower patients' healthcare decisions.

FY 2023 Hospital OPPS and ASC Payment System

On November 1, 2022, the Centers for Medicare and Medicaid Services (CMS) finalized the CY 2023 Medicare payment rates for hospital outpatient and ASC services. In addition to updating the payment rates, this final rule includes policies that align with several key goals of the Administration, including:

- Advancing health equity in rural areas
- Promoting competition in the health care system
- Promoting safe, effective and patient-centered care

This final rule furthers the agency's commitment to strengthening Medicare and use the lessons learned from the COVID-19 PHE, focusing on changes that will help close the equity gap.

Rural Emergency Hospitals (REHs)

Due to the growing concern that closures of rural hospitals and critical access hospitals (CAHs) are leading to a lack of services for people living in rural areas.

Section 125 of the Consolidated Appropriations Act, 2021 (CAA) established a new Medicare provider type – REHs, effective January 1, 2023. A rural emergency hospital is defined as:

- the facility must be enrolled in the Medicare Program on or after January 1, 2023
- does not provide any acute care inpatient services (other than posthospital extended care services furnished in a distinct part unit licensed as a Skilled Nursing Facility (SNF)) - with less than 50 beds
- has a transfer agreement with a level I or level II trauma center
- meets certain licensure requirements;
- must be a staffed emergency department;
- meets staff training and certification requirements; and
- Meets certain conditions of participation (CoPs) applicable to hospital emergency departments and CAHs with respect to emergency services
- An annual per patient average length of stay of 24 hours or less

Rural Emergency Hospitals continued…

NOTE: One of the most important REH enrollment provision being finalized in this final rule is that the facility may submit a Form CMS-855A, change of information application (rather than an initial enrollment application), in order to convert from a Critical Access Hospital (CAH) to an REH.

Services provided by REHs:

- Emergency services
- Observation services
- Outpatient medical and health services
- And other services specified by the secretary

Covered outpatient services provided by REHs will receive an additional 5% payment for each service. Beneficiaries will not be charged coinsurance on the additional 5%.

In addition, CMS is finalizing all outpatient department services, other than inpatient hospital services, that would otherwise be paid under the OPPS as REH services. REHs would be paid for furnishing these services at a rate that is equal to the OPPS payment rate for the equivalent covered outpatient department service increased by 5%.

CMS is also finalizing the proposal that REHs may provide outpatient services that are not otherwise paid under the OPPS (such as services paid under the Clinical Lab Fee Schedule) as well as post-hospital extended care services furnished in a unit of the facility that is a distinct part licensed as a skilled nursing facility; however, these services would not be considered REH services and would be paid under the applicable fee schedule and would not receive the 5% payment increase.

REH: Conditions of Participation

CMS has established Conditions of Participation (CoPs) to ensure the health and safety of patients who will receive REH services, while taking into consideration access and quality of care needs for the REH's patient population.

The specific requirements include:

- They must have a clinician on-call at all times and available within 30 or 60 minutes depending on the facility location
- The REH emergency department must be staffed 24 hours per day, 7 days per week by an individual competent in the needed skills to address emergency care
- REHs must develop, implement, and maintain an effective ongoing REH-wide data – driven Quality Assurance and Performance Improvement (QAPI) program which must address outcome indicators related to staffing
- The annual per-patient average length of stay cannot exceed 24 hours. The time calculation begins with registration, check-in or triage of the patient and ends with the discharge of the patient from the REH
- REHs must have an infection prevention and control; and an antibiotic stewardship program that adheres to nationally recognized guidelines.

Changes to the Inpatient Only List (IPO)

Since the inception of the OPPS, the IPO list has defined services that, due to their medical complexity, Medicare will only pay for these services when performed in the inpatient setting. CMS is finalizing their proposal to remove ten services from the IPO list after determining that these codes meet the current criteria for removal.

For CY 2023, The ten CPT codes listed below will be removed from the IPO list:

- CPT code 22632 (Arthodesis, posterior interbody technique)
- CPT code 21141 (Reconstruction midface, lefort, single piece)
- CPT code 21142 (Reconstruction midface, lefort 2 pieces)
- CPT code 21143 (Reconstruction midface, lefort 3 or more pieces)
- CPT code 21194 (Reconstruction of mandibular rami)
- CPT code 21196 (Reconstruction of mandibular rami and/or body)
- CPT code 21347 (Open treatment of nasomaxillary complex fracture)
- CPT code 21366 (Open treatment of complicated fracture(s) malar area)
- CPT code 21422 (Open treatment of palatal or maxillary fracture)
- CPT code 47550 (Biliary endoscopy, intraoperative)

Changes to the ASC Covered Procedure List (CPL)

The ASC covered procedure list (CPL) specifies the list of procedures that can be safely performed in an ASC. CMS evaluates the ASC CPL each year to determine whether procedures should be added or removed for the list.

In CY 2023, CMS is proposed to update the ASC CPL by the addition of one lymphatic procedure (CPT/HCPCS code 38531) to the list. This procedure will be separately paid under the OPPS.

Behavioral Health Services Furnished Remotely by Hospital Staff to Beneficiaries in Their Homes

During the PHE, many beneficiaries may be receiving mental health services in their homes from a clinical staff member of a hospital or CAH using communications technology under the flexibilities the CMS adopted to permit hospitals to furnish these services. The PHE-specific policy is referred to as Hospitals without Walls (HWW).

After the PHE ends, absent changes to regulations, the beneficiary would need to physically travel to the hospital to continue receiving these outpatient hospital services from hospital clinical staff. CMS is concerned that this may have a negative impact on access to care in areas where beneficiaries may only be able to access mental health services provided remotely by hospital staff and, during the PHE have become accustomed to receiving these services in their homes.

Behavioral Health Service Furnished Remotely by Hospital Staff to Beneficiaries in Their Home con't…

For CY 2023, CMS is establishing behavioral health services furnished remotely by clinical staff of hospital outpatient departments (including staff of CAHs) via the use of telecommunications technology to beneficiaries in their home, to be considered covered outpatient services for which payment is made under the OPPS.

CMS is finalizing its proposal to require that payment for behavioral services furnished remotely, to beneficiaries in their homes, may only be made if the beneficiary receives:

- An **in-person service within 6 months** prior to the first-time hospital clinical staff provides behavioral health services remotely and
- That there must be an in-person service, without the use of communications technology, **within 12 months** of each behavioral health service furnished remotely

For CY 2023, CMS is finalizing the proposal to permit exceptions to the in-person visit requirement when the hospital clinical staff member and beneficiary agree that the risks and burdens of an in-person service outweigh the benefits of it among other requirements.

Behavioral Health Service Furnished Remotely by Hospital Staff to Beneficiaries in Their Home con't…

CMS is also clarifying that in instances where there is ongoing clinical relationship between the practitioner and beneficiary at the time the PHE ends, the in-person requirement for ongoing, not newly initiated, treatment will apply.

In addition, CMS is finalizing its proposal that audio-only interactive telecommunications systems may be used to furnish these services in instances where the beneficiary is unable to use, or does not have access to two-way, audio/video technology

NOTE: Audio-only communications can help advance equity, since many rural and underserved communities lack stable access to broadband services.

Rural Sole Community Hospital Exemption to the Clinic Visit Payment Policy

Currently, CMS pays the Physician Fee Schedule (PFS) equivalent payment rate for the hospital outpatient clinic visit service described by HCPCS code G0463 when furnished in an excepted off-campus provider-based department (PBD). The PFS – equivalent payment rate is approximately 40% of the proposed OPPS payment rate (that is 60% percent less than the proposed OPPS rate), and the clinic visit is the most frequently billed service under the OPPS.

In order to maintain access to care in rural areas, CMS is finalizing the proposal to exempt Rural Sole Community Hospital (SCHs) from this policy and pay for clinic visits furnished in excepted off-campus PBDs of these hospitals at the full OPPS rate. . This exemption for rural SCHs is in keeping with prior CMS policies to provide rural SCHs a 7.1% add-on payment for OPPS services, to account for their higher costs compared to other hospitals.

CMS believes that implementing this exception would help to maintain access to care in rural areas.

Hospital Outpatient/ASC/REH Quality Reporting Programs continued

Rural Emergency Quality Reporting (REHQR) Program

Section 1861(kkk)(7) of the Social Security Act, requires the Secretary to establish quality measurement reporting requirements for REHs.

CMS is finalizing that, in order for REHs to participate in the REHQR Program, they must have an account with the Hospital Quality Reporting (HQR) System secure portal and a designated Security Official (SO)

CMS is seeking comments on several measures for the new Rural Emergency Hospital Quality Reporting Program as well as on topics of interest for the REHQR Program for future rule making, including:

- Behavioral/mental health
- Rural maternal health, and
- Rural telehealth services

Public Health Emergency for COVID-19

Title	Disaster Type	State/ Territory	Signed Date
Renewal of Determination that a Public Health Emergency Exists Nationwide as a Result of the Continued Consequences of an Outbreak of Monkeypox	Monkeypox	National	November 2, 2022
Renewal of Determination that a Public Health Emergency Exists As a Result of the Countinued Consequences of the Coronavirus Disease 2019 (COVID-19) Pandemic	COVID-19	National	October 13, 2022
Determination that a Public Health Emergency Exists As a Result of the Consequences of Hurricane Ian on the State of South Carolina	Hurricane	South Carolina	September 30, 2022
Renewal of Determination that a Public Health Emergency Exists Nationwide as a Result of the Continued Consequences of the Opioid Crisis	Opioid Crisis	National	September 29, 2022

Declarations of a Public Health Emergency

Letter to Governors on the COVID-19 Response

On January 22, 2021, Acting HHS Secretary Norris Cochran reached out to governors across the country to share details of the public health emergency declaration for COVID-19. Among other things, the Acting Secretary Cochran indicated that HHS will provide states with 60 days notice prior to the termination of the public health emergency declaration for COVID-19. To learn more about the extension and other flexibilities that are tied to the public health emergency declaration, please read the full text of Acting Secretary Cochran's letter.

Read Full Text

Public Health Actions

Declarations of a Public Health Emergency

Public Health Emergency Determinations to Support an Emergency Use Authorization

Section 1135 Waivers

Emergency Use Authorizations

The CMS COVID-19 Response

Care by Phone

Patients can consult with a doctor, nurse practitioner, psychologist, and others and

Medicare will cover it.

Telehealth

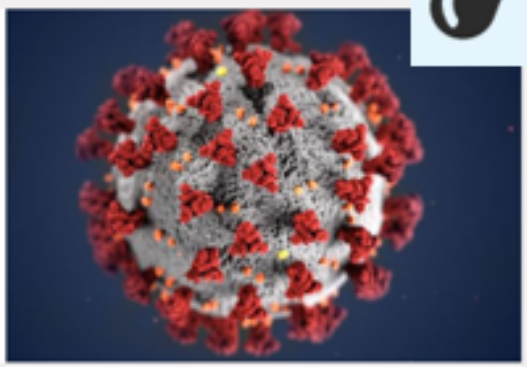
People with Medicare can now get telehealth services from their home, increasing their access to care.

Expanding Hospital Capacity

Community resources like hotels, convention centers and surgery centers can be converted for hospital care.

COVID-19 Vaccine Policies & Guidance

We're giving you the information you need to provide the COVID-19 vaccine. We have many resources about coverage and billing for providers, state Medicaid plans, and private health plans.



COVID-19 Emergency Declaration Blanket Waivers for Health Care Providers

https://www.cms.gov/files/document/covid-19-emergency-declaration-waivers.pdf

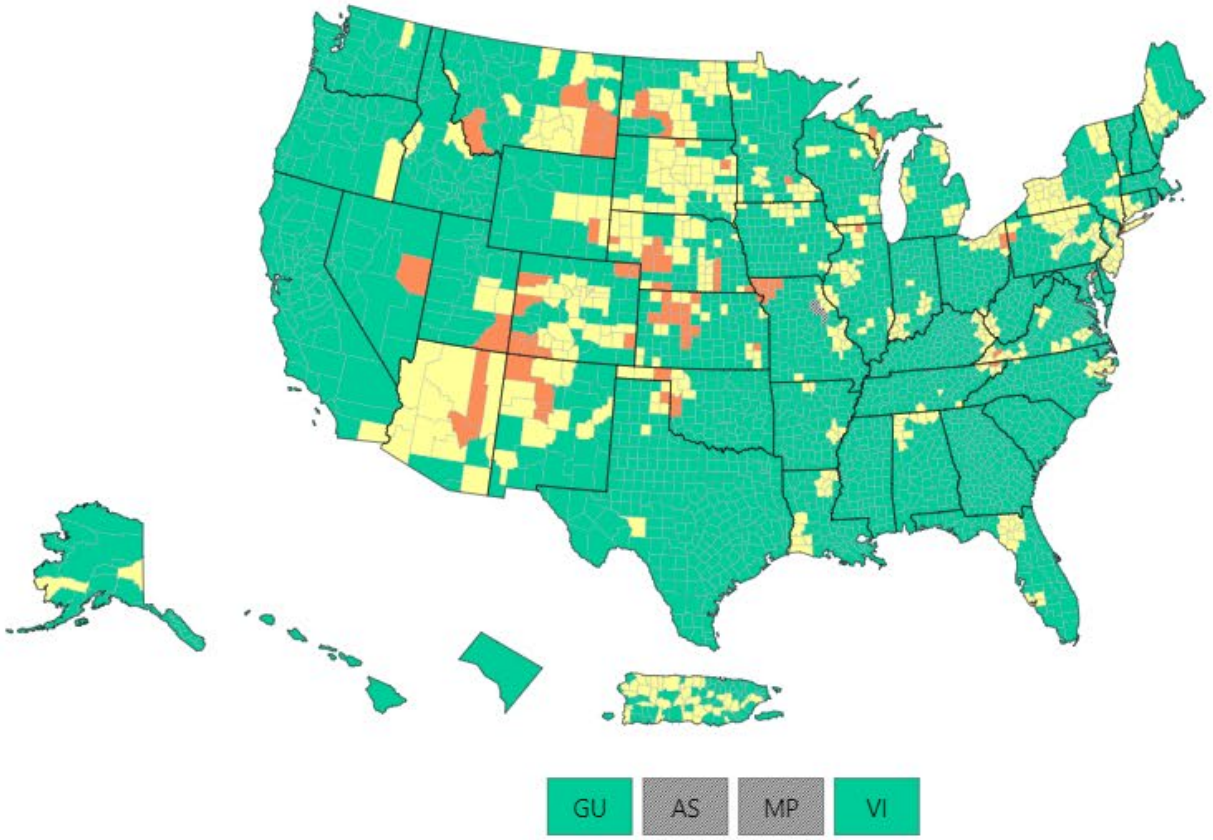
https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

CMS Support for When the PHE Ends

- CMS' strategic plan includes a cross-cutting initiative to address the current PHE and ensure that CMS has a roadmap to support a health care system that is more resilient and better prepared to adapt to future disasters and emergencies that we know we can expect.
- CMS has developed a roadmap for the eventual end of the Medicare PHE waivers and flexibilities, and is sharing information on what health care facilities and providers can do to prepare for future events.
- Released a set of 16 fact sheets which summarize the current status of Medicare Blanket waivers and flexibilities by provider type as well as flexibilities applicable to the Medicaid community.
- https://www.cms.gov/blog/creating-roadmap-end-covid-19-public-health-emergency

COVID-19 Community Levels of All Counties in US



COVID-19 Community Levels in US by County

	Total	Percent	% Change
High	90	2.8%	0.19%
Medium	537	16.68%	– 4.31%
Low	2592	80.52%	4.12%

How are COVID-19 Community Levels calculated?

Low Medium High No Data

Tue Nov 22 2022 13:15:32 GMT-0600

Know Your COVID-19 Community Level

- **People may choose to wear a mask at any time.** Masks are recommended in indoor public transportation settings and may be required in other places by local or state authorities.
- At all COVID-19 Community Levels (low, medium, and high):
  - Stay up to date on vaccination, including recommended booster doses.
  - Maintain ventilation improvements.
  - Avoid contact with people who have suspected or confirmed COVID-19.
  - Follow recommendations for isolation if you have suspected or confirmed COVID-19.
  - Follow the recommendations for what to do if you are exposed to someone with COVID-19.
  - If you are at high risk of getting very sick, talk with a healthcare provider about additional prevention actions.

Table 2. COVID-19 vaccination schedule for people who are not moderately or severely immunocompromised

Age group	Number of primary doses	Number of bivalent booster doses	Recommended bivalent booster dose*	Interval between 1st and 2nd primary dose†	Interval between 2nd and 3rd primary dose	Interval between primary series and booster dose‡
Moderna primary series						
6 months–4 years	2	NA	NA	4–8 weeks	NA	NA
5 years	2	1	Pfizer-BioNTech	4–8 weeks	NA	At least 2 months
6–11 years	2	1	Moderna or Pfizer-BioNTech	4–8 weeks	NA	At least 2 months
12 years and older	2	1	Moderna or Pfizer-BioNTech	4–8 weeks	NA	At least 2 months
Novavax primary series						
12 years and older	2	1	Moderna or Pfizer-BioNTech	3–8 weeks	NA	At least 2 months
Pfizer-BioNTech primary series						
6 months–4 years	3	NA	NA	3–8 weeks	At least 8 weeks	NA
5 years	2	1	Pfizer-BioNTech	3–8 weeks	NA	At least 2 months
6–11 years	2	1	Moderna or Pfizer-BioNTech	3–8 weeks	NA	At least 2 months
12 years and older	2	1	Moderna or Pfizer-BioNTech	3–8 weeks	NA	At least 2 months

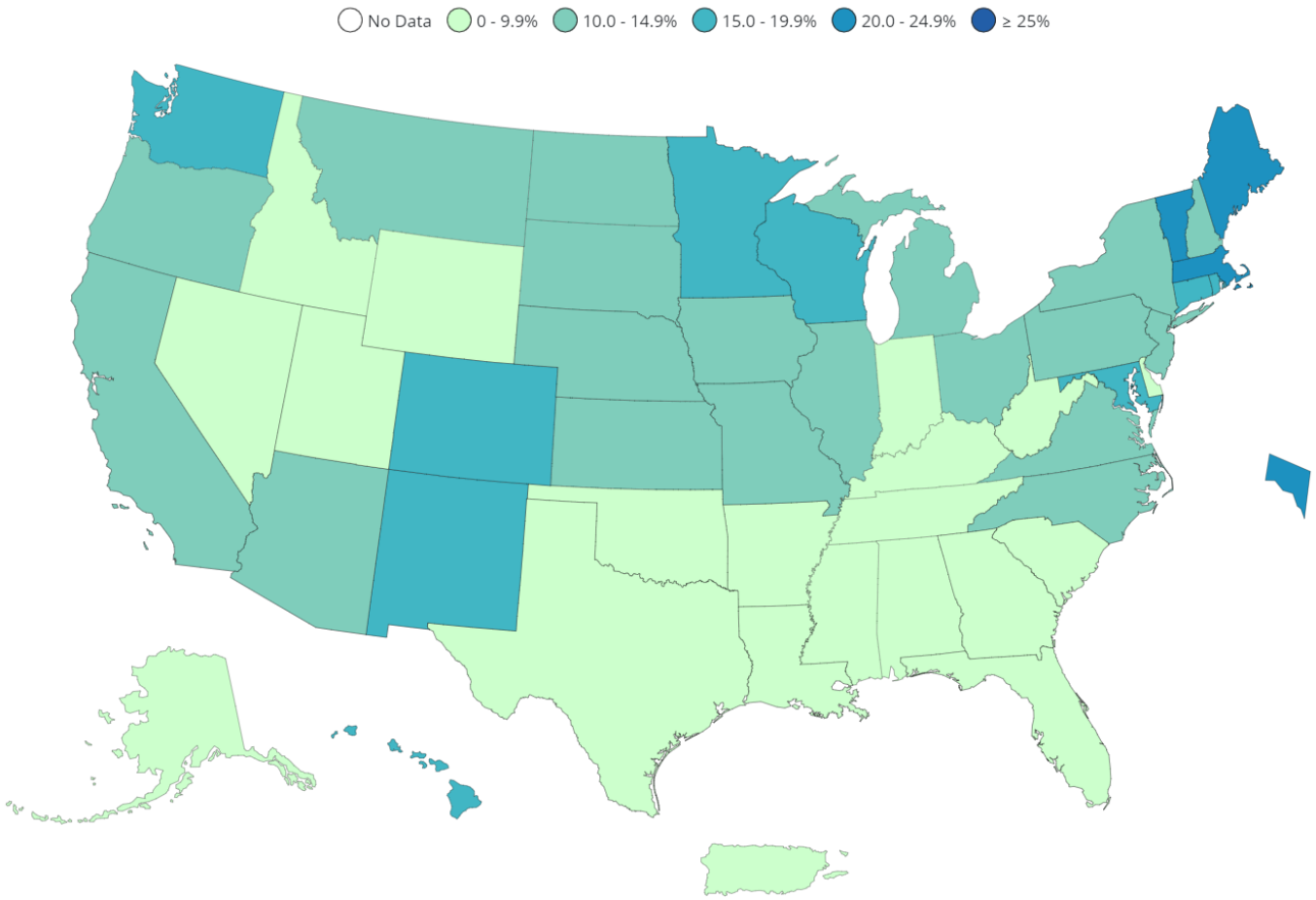
Abbreviation: NA = not authorized

*A monovalent Novavax booster dose (instead of a bivalent mRNA booster dose) may be used in limited situations in people ages 18 years and older who completed a primary series using any COVID-19 vaccine, have not received any previous booster dose(s), and are unable (i.e., contraindicated or not available) or unwilling to receive an mRNA vaccine and would otherwise not receive a booster dose. The monovalent Novavax booster dose is administered **at least 6 months** after completion of any primary series.

COVID Vaccines – No Cost to Patient

- People with Medicare, Medicaid, Children's Health Insurance Program (CHIP) coverage, private insurance coverage, or no health coverage can get COVID-19 vaccines, including the updated Moderna and Pfizer-BioNTech COVID-19 vaccines, at no cost, for as long as the federal government continues purchasing and distributing these COVID-19 vaccines.

Percent of the Total Population Population 5 Years of Age and Older Years of Age with an Updated (Bivalent) Booster Dose Reported to CDC by Jurisdictions and Select Federal Entities



Territories

GU AS PW FM MP MH VI

Federal Entities

BoP DoD IHS VHA

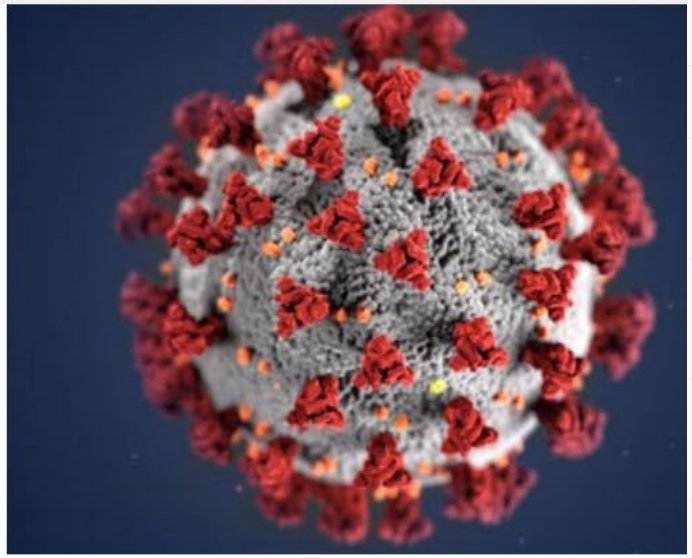
Data for Federal Entities are presented here and are also incorporated into the respective jurisdictional totals

COVID-19 Vaccine and Therapeutics Toolkits

COVID-19 Vaccine Policies & Guidance

We're giving you the information you need to be ready for the COVID-19 vaccine when it's available. If we can prepare a wide pool of providers to administer the COVID-19 vaccine, then we can ensure the vaccine is covered and available free of charge for every American.

Read IFC 4 (PDF)



COVID-19

- Enrollment for Administering COVID-19 Vaccine Shots
- Coding for COVID-19 Vaccine Shots
- Medicare COVID-19 Vaccine Shot Payment
- Medicare Billing for COVID-19 Vaccine Shot Administration
- SNF: Enforcement Discretion Relating to Certain Pharmacy Billing
- Beneficiary Incentives for COVID-19 Vaccine Shots
- CMS Quality Reporting for COVID-19 Vaccine Shots
- *New* Monoclonal Antibody COVID-19 Infusion

Vaccine guidance: https://www.cms.gov/covidvax

Clinician/provider toolkit: https://www.cms.gov/covidvax-provider

FAQs on billing therapeutics: https://www.cms.gov/files/document/03092020-covid-19-faqs-508.pdf

Coadministration of Flu & COVID-19 Vaccines

- COVID-19 vaccines **may be administered without regard to timing of other vaccines**. This includes simultaneous administration of COVID-19 vaccine and other vaccines on the same day.
- **If multiple vaccines are administered at a single visit, administer each injection in a different injection site.** For people ≥11 years, the deltoid muscle can be used for more than one intramuscular injection administered at different sites in the muscle. For children (5–10 years), if more than two vaccines are injected in a single limb, the vastus lateralis muscle of the anterolateral thigh is the preferred site because of greater muscle mass.
- Best practices for multiple injections include:
  - Label each syringe with the name and the dosage (amount) of the vaccine, lot number, the initials of the preparer, and the exact beyond-use time, if applicable.
  - Separate injection sites by 1 inch or more, if possible.
  - **Administer the COVID-19 vaccines and vaccines that may be more likely to cause a local reaction in different limbs, if possible.**

https://www.cdc.gov/vaccines/covid-19/clinical-considerations/covid-19-vaccines-us.html#Coadministration

NOVEMBER 22, 2022

FACT SHEET: Biden Administration Announces Six-Week Campaign to Get More Americans their Updated COVID-19 Vaccine Before End of the Year

Administration to focus efforts on seniors and high-risk communities

Today, the Biden Administration is announcing a six-week campaign through the end of the year urging Americans to get their updated COVID-19 vaccine. With winter and holiday gatherings right around the corner, more Americans getting their updated vaccine will help avoid thousands of preventable COVID-19 deaths. The six-week campaign will focus on reaching seniors and

Outpatient Therapeutics for COVID-19

- Paxlovid (nirmatrelvir and ritonavir)
- Veklury (remdesivir)
- Lagevrio (molnupiravir)
- Bebtelovimab

- https://aspr.hhs.gov/COVID-19/Therapeutics/Documents/side-by-side-overview.pdf

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