CY23 Medicare Physician Fee Schedule Proposed Rule

On July 7, 2022, the Centers for Medicare and Medicaid Services (CMS) released the calendar year (CY) 2023 Medicare Physician Fee Schedule proposed rule (MPFS). Comments must be submitted to CMS by September 6. The final rule is typically released in early November and the provisions of the rule are effective on January 1, 2023.

Conversion Factor

CMS is proposing a reduction in the 2023 Medicare conversion factor (CF) of about 4.5%; from $34.6062 to $33.0775. This is largely the result of the expiration of the 3% increase to the conversion factor at the end of calendar year 2022 as required by law. Congress will be under pressure to restore the reduction prior to the start of 2023.

Impact of Proposed Rule on Epilepsy Center Services

Attached to this summary are the CMS impact table (attachment 1), which shows the overall impact of changes made by the rule on each specialty and charts (attachment 2) created by NAEC showing the relative values and payment rates for neurology, epilepsy surgery and evaluation and management (E/M) services for CY 2023, along with a comparison to the payment rates published in the final MPFS for CY 2022. The physician work relative values for most neurology services are not changing significantly. Practice expense values and malpractice values are fluctuating based on updates on labor and malpractice insurance costs being recognized by CMS. The payment reductions seen for neurology and E/M services largely reflect the decrease in the conversion factor in the proposed rule.

Evaluation and Management (E/M)

In 2021, CMS adopted major changes to the office and outpatient E/M visits as recommended by the CPT Editorial Panel and the RUC, which allowed physicians to select the E/M visit level to bill based on either total time spent on the date of a patient encounter or the medical decision making utilized in the provision of the visit. In this rule, CMS is proposing similar revisions to other E/M visit code sets, including inpatient and observation visits, emergency department (ED) visits, nursing facility visits, domiciliary or rest home visits, home visits, and cognitive impairment assessment. CMS will allow practitioners to use time or medical decision-making to select the E/M visit level. History and physical exam would be considered, as medically appropriate, and would no longer be used to select visit level. CMS is adopting additional changes, including the deletion of observation CPT codes, which would be merged into the existing hospital care CPT code set. CMS also is proposing Medicare-specific coding for prolonged services, which is consistent with CMS' previously finalized approach to prolonged office and outpatient E/M services.

New Prolonged Inpatient/Observation E/M Code

CMS is proposing a new HCPCS code, GXXX1, to describe prolonged services associated with certain types of E/M services.

- GXXX1: *Prolonged hospital inpatient or observation care evaluation and management service(s) beyond the total time for the primary service (when the primary service has been selected using time on the date of the primary service); each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99223, 99233, and 99236 for hospital inpatient or observation care evaluation and management services). (Do not report GXXX1 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 993X0). (Do not report GXXX1 for any time unit less than 15 minutes)*).

Split (or Shared) E/M Visits

A split (or shared) visit refers to an E/M service performed by both a physician and a non-physician practitioner (NPP) in the same group practice. Longstanding CMS policy has been that the physician can bill for the split/shared service if he/she performs a "substantive portion" of the encounter. Medicare reimbursement for split/shared services is at 100 percent of the PFS rate, when the physician bills for the service, while reimbursement is at 85 percent of the PFS rate when NPPs bill for the service.

In this proposed rule, CMS proposes a one-year delay of its policy (included in the 2022 MPFS) requiring a physician to see the patient for more than half of the total time of a split or shared E/M visit in order to bill for the service. Through calendar year 2023, physicians would continue to bill split or shared visits based on the current definition of substantive portion as one of the following: history, exam, medical decision-making, or more than half of total time.

CMS believes that this delay will allow for a one-year transition for providers to get accustomed to these changes and adopt their workflow in practice as well as for the implementation of the new coding and payment policies for other E/M services, which become effective in CY 23.

Payment for Medicare Telehealth Services

In this proposed rule, CMS is implementing the provisions of the Consolidated Appropriations Act of 2022, which extended certain telehealth flexibilities, including the telephone E/M codes (99441-99443) and patients receiving telehealth services from any location, as allowed under the COVID-19 public health emergency (PHE), for an additional 151 days after the end of the PHE.

As a reminder, telehealth services under Medicare are assigned to one of three categories. Category 1 includes services that are similar to professional consultations, office visits, and office psychiatry services currently on the Medicare Telehealth Services List. Category 2 includes services that are not like those on the current Medicare Telehealth Services List (non-E/M). If a service is included in Category 1 or 2, it is considered a covered service via telehealth. Category 3, which was newly created in 2021 due to the COVID-19 pandemic, includes services added to the Medicare Telehealth Services List on a temporary basis and under current policy, these services are slated to remain on the list through the end of 2023.

CMS is also proposing to add newly proposed HCPCS prolonged services code GXXX1 (described above) to the Medicare Telehealth Services list on a Category 1 basis (a covered telehealth service).

Telephone E/M Services

CMS received many requests to add the telephone E/M codes (99441-99443) to the Category 3 telehealth list, but the agency did not include a proposal to do this in the rule. CMS believes that

outside the circumstances of the PHE, the telephone E/M services would not be analogous to in-person care; nor would they be a substitute for a face-to-face encounter, and therefore, CMS does not believe it would be appropriate for these codes to remain on the Medicare Telehealth Services List after the end of the PHE and the 151-day post-PHE extension period.

Services Proposed for Removal from the Medicare Telehealth Services List After 151 Days Following the End of the PHE

The Consolidated Appropriations Act of 2022 extends some of the flexibilities implemented during the PHE for COVID-19 for an additional 151 days after the end of the PHE. During the additional 151 days, the originating site for the telehealth service can be any site in the U.S. at which the beneficiary is located when the service is furnished, including the beneficiary's home. Services extended for the additional 151 days, include, initial observation care (99218-99220); initial hospital care (99221-99223); observation/hospital same day (99234-99236); telephone E/M (99441-99443).

For coding and billing purposes, CMS is proposing that Medicare telehealth services furnished on or before the 151st day after the end of the PHE, will continue to be processed for payment as Medicare telehealth claims when accompanied with the modifier "95" and that physicians and other practitioners should continue to report the place of service (POS) code that would have been reported had the service been furnished in-person. After the 151-day extension, telehealth claims will require the appropriate POS indicator rather than modifier "95".

Expiration of PHE Flexibilities for Direct Supervisions Requirements

Under the COVID-19 PHE, CMS has allowed for direct supervision, as it pertains to supervision of diagnostic tests, physicians' services, and some hospital outpatient services, to allow the supervising professional to be immediately available through virtual presence using real-time audio/video technology, instead of requiring their physical presence. Currently, after December 31 of the year in which the PHE ends, this flexibility will end and the pre-PHE rules for direct supervision will apply. CMS is continuing to seek information on whether the flexibility to meet the immediate availability requirement for direct supervision using real-time audio/video technology should potentially be made permanent. They are also seeking comment regarding the possibility of permanently allowing immediate availability for direct supervision through virtual presence using real-time, audio/video technology for only a subset of services.

Removal of National Coverage Determination (NCD) 160.22, Ambulatory EEG Monitoring

At the request of ACNS, AAN and NAEC, CMS is proposing to remove the National Coverage Determination (NCD) for Ambulatory EEG Monitoring that was established in 1984. The organizations made the request in 2020 after the changes in long-term EEG/VEEG coding were made, making the case that the policy was no longer clinically pertinent, and resulted in unnecessary testing and cost to the Medicare program.

NCD 160.22 requires that a "resting EEG" be performed before Medicare would cover an "ambulatory EEG." Medicare and some private insurers have referenced this policy and required that a routine EEG be provided to a patient before any long-term EEG/VEEG could be covered.

CMS includes the following justification for the removal of the NCD:

- The NCD contains outdated language that is inconsistent with, and contrary to the current standards of care. For example, the NCD references cassette tapes.
- The NCD uses the word "ambulatory" implying certain sites of service whereas this diagnostic test is not site specific.
- The 24-hour duration of monitoring is no longer consistent with current coding structures, which permit monitoring in increments including 36-60 hours, 60-84 hours, and >84 hours.
- The language "should always be preceded by a resting EEG" could potentially create waste and a burden.

If the proposal to remove the NCD is finalized, coverage of long-term EEGs/VEEGs provided at any site of service would be covered if medically necessary or based on any local Medicare Administrative Contractors (MACs) local coverage decisions. The removal of the NCD may motivate Medicare Administrative Contractors to provide updated guidance for ambulatory long-term EEGs/VEEGs. CMS requests public comments on this proposal and will use the comments to help inform their decision to remove the NCD, retain as current policy, or reconsider the NCD by opening a National Coverage Analysis. NAEC will submit comments in support of this proposal.

Quality Payment Program

MIPS Value Pathways

The Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) are a subset of measures and activities that can be used to meet MIPS reporting requirements beginning in the 2023 performance year. The MVP framework aims to align and connect measures and activities across the quality, cost, and improvement activities, performance categories of MIPS for different specialties and conditions. MIPS-eligible clinicians will be required to submit measures in five categories (quality, improvement activities, cost, population health, and promoting interoperability). Measures will be chosen from a list curated by CMS that relate to the specific MVP. The measure lists for population health and promoting interoperability will be the same regardless of which MVP is selected.

CMS aims to sunset the traditional MIPS reporting after the 2027 performance year, replacing it completely with MVPs or the Alternative Payment Model Performance Pathway. Similar to MIPS, physicians participating in MVP can earn a payment adjustment for Part B covered professional services based on CMS's evaluation of reported measures.

In this year's proposed rule, CMS is proposing five new MVPs. The following MVP is of interest to NAEC Members:

Optimal Care for Patients with Episodic Neurological Conditions

The proposed Optimal Care for Patients with Episodic Neurological Conditions MVP focuses on the clinical theme of promoting quality care for patients suffering from episodic neurological conditions. This proposed MVP would be most applicable to clinicians specializing in epilepsy. The information from the rule on this MVP, which includes the measures that would be reported is attachment 3.

Additional resources include:

- CMS Press Release: https://www.cms.gov/newsroom/press-releases/cms-proposes-physician-payment-rule-expand-access-high-quality-care
- Physician Payment Schedule Fact Sheet: https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-proposed-rule
- QPP Fact Sheet: https://qpp-cm-prod-content.s3.amazonaws.com/uploads/1972/2023%20Quality%20Payment%20Program%20Proposed%20Rule%20Resources.zip
- CMS Blog on Behavioral Health Care: https://www.cms.gov/blog/strengthening-behavioral-health-care-people-medicare

Estimated Impact of the Rule by Specialty

(A) Specialty	(B) Allowed Charges (mil)	(C) Impact of Work RVU Changes	(D) Impact of PE RVU Changes	(E) Impact of MP RVU Changes	(F) Combined Impact
Audiologist	$70	0%	1%	-1%	0%
Cardiac Surgery	$197	-1%	-1%	0%	-1%
Cardiology	$6,298	0%	-1%	0%	-1%
Chiropractic	$669	-1%	1%	0%	0%
Clinical Psychologist	$784	-1%	0%	-1%	-2%
Clinical Social Worker	$853	-1%	0%	-1%	-2%
Colon and Rectal Surgery	$155	-1%	-1%	0%	-1%
Critical Care	$351	1%	0%	1%	1%
Dermatology	$3,751	-1%	0%	0%	0%
Diagnostic Testing Facility	$811	0%	3%	0%	2%
Emergency Medicine	$2,530	0%	0%	1%	1%
Endocrinology	$532	0%	0%	0%	0%
Family Practice	$5,777	0%	0%	0%	0%
Gastroenterology	$1,589	0%	0%	1%	0%
General Practice	$371	0%	0%	0%	0%
General Surgery	$1,758	-1%	-1%	0%	-1%
Geriatrics	$175	2%	0%	0%	3%
Hand Surgery	$255	-1%	0%	0%	0%
Hematology/Oncology	$1,707	0%	-1%	0%	-1%
Independent Laboratory	$594	0%	-1%	0%	-1%
Infectious Disease	$586	4%	0%	1%	5%
Internal Medicine	$9,804	2%	0%	1%	3%
Interventional Pain Mgmt	$924	-1%	-1%	0%	-1%
Interventional Radiology	$465	-1%	-3%	0%	-4%
Multispecialty Clinic/Other Phys	$150	0%	-1%	0%	0%
Nephrology	$2,021	1%	0%	0%	1%
Neurology	$1,397	0%	0%	0%	-1%
Neurosurgery	$727	-1%	0%	1%	0%
Nuclear Medicine	$53	-1%	-1%	-1%	-3%
Nurse Anes / Anes Asst	$1,116	-1%	0%	0%	-1%
Nurse Practitioner	$5,802	1%	0%	0%	2%
Obstetrics/Gynecology	$592	-1%	0%	0%	-1%
Ophthalmology	$4,835	-1%	0%	0%	0%
Optometry	$1,306	-1%	0%	0%	-1%
Oral/Maxillofacial Surgery	$72	-1%	-1%	0%	-2%
Orthopedic Surgery	$3,461	-1%	0%	0%	0%
Other	$58	0%	-1%	0%	-2%
Otolarngology	$1,134	-1%	0%	0%	-1%
Pathology	$1,163	-1%	0%	0%	-1%
Pediatrics	$57	0%	0%	0%	0%
Physical Medicine	$1,090	2%	0%	0%	2%
Physical/Occupational Therapy	$4,978	-1%	1%	-1%	-1%
Physician Assistant	$3,165	0%	0%	0%	0%
Plastic Surgery	$320	-1%	0%	0%	0%
Podiatry	$1,991	-1%	-1%	0%	-2%
Portable X-Ray Supplier	$77	0%	2%	0%	1%
Psychiatry	$978	1%	0%	0%	2%
Pulmonary Disease	$1,395	1%	0%	1%	2%
Radiation Oncology and Radiation Therapy Centers	$1,609	-1%	0%	0%	-1%
Radiology	$4,712	-1%	-1%	-2%	-3%
Rheumatology	$546	-1%	-1%	0%	-2%
Thoracic Surgery	$315	-1%	-1%	0%	-1%
Urology	$1,752	-1%	-1%	0%	-1%
Vascular Surgery	$1,098	0%	-3%	0%	-3%

2023 Proposed Physician Fee Schedule (CMS–1770–P)							
Payment Rates for Medicare Physician Services - Neurology							
CPT Code	Mod	Descriptor	2023			2022	% payment change 2022 to 2023
			Work RVUs	Total RVUs	Payment CF=$33.0775	Payment CF=$34.6062	
95700		Eeg cont rec w/vid eeg tech	0.00	0.00	$0.00	$0.00	NA
95705		Eeg w/o vid 2-12 hr unmntr	0.00	0.00	$0.00	$0.00	NA
95706		Eeg wo vid 2-12hr intmt mntr	0.00	0.00	$0.00	$0.00	NA
95707		Eeg w/o vid 2-12hr cont mntr	0.00	0.00	$0.00	$0.00	NA
95708		Eeg wo vid ea 12-26hr unmntr	0.00	0.00	$0.00	$0.00	NA
95709		Eeg w/o vid ea 12-26hr intmt	0.00	0.00	$0.00	$0.00	NA
95710		Eeg w/o vid ea 12-26hr cont	0.00	0.00	$0.00	$0.00	NA
95711		Veeg 2-12 hr unmonitored	0.00	0.00	$0.00	$0.00	NA
95712		Veeg 2-12 hr intmt mntr	0.00	0.00	$0.00	$0.00	NA
95713		Veeg 2-12 hr cont mntr	0.00	0.00	$0.00	$0.00	NA
95714		Veeg ea 12-26 hr unmntr	0.00	0.00	$0.00	$0.00	NA
95715		Veeg ea 12-26hr intmt mntr	0.00	0.00	$0.00	$0.00	NA
95716		Veeg ea 12-26hr cont mntr	0.00	0.00	$0.00	$0.00	NA
95717	Hospital	Eeg phys/qhp 2-12 hr w/o vid	2.00	2.98	$98.57	$101.74	-3.1%
95717	Office	Eeg phys/qhp 2-12 hr w/o vid	2.00	3.01	$99.56	$102.78	-3.1%
95718	Hospital	Eeg phys/qhp 2-12 hr w/veeg	2.50	3.93	$129.99	$135.66	-4.2%
95718	Office	Eeg phys/qhp 2-12 hr w/veeg	2.50	4.00	$132.31	$137.73	-3.9%
95719	Hospital	Eeg phys/qhp ea incr w/o vid	3.00	4.61	$152.49	$158.15	-3.6%
95719	Office	Eeg phys/qhp ea incr w/o vid	3.00	4.67	$154.47	$159.53	-3.2%
95720	Hospital	Eeg phy/qhp ea incr w/veeg	3.86	6.05	$200.12	$208.68	-4.1%
95720	Office	Eeg phy/qhp ea incr w/veeg	3.86	6.15	$203.43	$212.14	-4.1%
95721	Hospital	Eeg phy/qhp>36<60 hr w/o vid	3.86	6.03	$199.46	$207.64	-3.9%
95721	Office	Eeg phy/qhp>36<60 hr w/o vid	3.86	6.14	$203.10	$211.79	-4.1%
95722	Hospital	Eeg phy/qhp>36<60 hr w/veeg	4.70	7.34	$242.79	$253.32	-4.2%
95722	Office	Eeg phy/qhp>36<60 hr w/veeg	4.70	7.48	$247.42	$258.16	-4.2%
95723	Hospital	Eeg phy/qhp>60<84 hr w/o vid	4.75	7.36	$243.45	$255.05	-4.5%
95723	Office	Eeg phy/qhp>60<84 hr w/o vid	4.75	7.51	$248.41	$260.24	-4.5%
95724	Hospital	Eeg phy/qhp>60<84 hr w/veeg	6.00	9.29	$307.29	$321.84	-4.5%
95724	Office	Eeg phy/qhp>60<84 hr w/veeg	6.00	9.46	$312.91	$327.72	-4.5%
95725	Hospital	Eeg phy/qhp>84 hr w/o vid	5.40	8.42	$278.51	$292.42	-4.8%
95725	Office	Eeg phy/qhp>84 hr w/o vid	5.40	8.60	$284.47	$299.00	-4.9%
95726	Hospital	Eeg phy/qhp>84 hr w/veeg	7.58	11.79	$389.98	$408.70	-4.6%
95726	Office	Eeg phy/qhp>84 hr w/veeg	7.58	12.01	$397.26	$416.31	-4.6%
95812		Eeg 41-60 minutes	1.08	10.37	$343.01	$355.75	-3.6%
95812	TC	Eeg 41-60 minutes	0.00	8.75	$289.43	$298.31	-3.0%
95812	26	Eeg 41-60 minutes	1.08	1.62	$53.59	$57.45	-6.7%
95813		Eeg over 1 hour	1.63	12.85	$425.05	$440.19	-3.4%
95813	TC	Eeg over 1 hour	0.00	10.40	$344.01	$352.64	-2.4%
95813	26	Eeg over 1 hour	1.63	2.45	$81.04	$87.55	-7.4%
95816		Eeg awake and drowsy	1.08	11.49	$380.06	$392.43	-3.2%
95816	TC	Eeg awake and drowsy	0.00	9.87	$326.47	$334.99	-2.5%
95816	26	Eeg awake and drowsy	1.08	1.62	$53.59	$57.45	-6.7%
95819		Eeg awake and asleep	1.08	13.37	$442.25	$460.61	-4.0%
95819	TC	Eeg awake and asleep	0.00	11.74	$388.33	$402.82	-3.6%
95819	26	Eeg awake and asleep	1.08	1.63	$53.92	$57.79	-6.7%
95822		Eeg coma or sleep only	1.08	12.49	$413.14	$427.73	-3.4%
95822	TC	Eeg coma or sleep only	0.00	10.86	$359.22	$369.94	-2.9%
95822	26	Eeg coma or sleep only	1.08	1.63	$53.92	$57.79	-6.7%
95824	26	Eeg cerebral death only	0.74	1.11	$36.72	$39.45	-6.9%
95829		Surgery electrocorticogram	6.20	52.86	$1,748.48	$1,875.31	-6.8%
95829	TC	Surgery electrocorticogram	0.00	43.49	$1,438.54	$1,539.63	-6.6%
95829	26	Surgery electrocorticogram	6.20	9.37	$309.94	$335.68	-7.7%
95830	Hospital	Insert electrodes for EEG	1.70	2.68	$88.65	$92.74	-4.4%
95830	Office	Insert electrodes for EEG	1.70	20.78	$687.35	$743.00	-7.5%
95836		Ecog impltd brn npgt <30 d	1.98	3.11	$102.87	$108.32	-5.0%
95954		Eeg monitoring/giving drugs	2.45	12.10	$400.24	$416.66	-3.9%
95954	TC	Eeg monitoring/giving drugs	0.00	9.02	$298.36	$306.61	-2.7%
95954	26	Eeg monitoring/giving drugs	2.45	3.08	$101.88	$110.05	-7.4%
95955		Eeg during surgery	1.01	5.72	$189.20	$210.06	-9.9%
95955	TC	Eeg during surgery	0.00	4.20	$138.93	$156.07	-11.0%
95955	26	Eeg during surgery	1.01	1.52	$50.28	$53.99	-6.9%
95957		Eeg digital analysis	1.98	8.20	$271.24	$267.16	1.5%
95957	TC	Eeg digital analysis	0.00	5.31	$175.64	$164.03	7.1%
95957	26	Eeg digital analysis	1.98	2.89	$95.59	$103.13	-7.3%
95958		Eeg monitoring/function test	4.24	18.58	$614.58	$645.75	-4.8%
95958	TC	Eeg monitoring/function test	0.00	12.15	$401.89	$415.27	-3.2%
95958	26	Eeg monitoring/function test	4.24	6.43	$212.69	$230.48	-7.7%
95961		Electrode stimulation brain	2.97	9.19	$303.98	$333.26	-8.8%
95961	TC	Electrode stimulation brain	0.00	4.63	$153.15	$169.57	-9.7%
95961	26	Electrode stimulation brain	2.97	4.56	$150.83	$163.69	-7.9%
95962		Electrode stim brain add-on	3.21	7.94	$262.64	$273.74	-4.1%
95962	TC	Electrode stim brain add-on	0.00	3.06	$101.22	$98.63	2.6%
95962	26	Electrode stim brain add-on	3.21	4.88	$161.42	$175.11	-7.8%
95965	26	Meg spontaneous	7.99	11.74	$388.33	$420.12	-7.6%
95966	26	Meg evoked single	3.99	5.99	$198.13	$213.87	-7.4%
95967	26	Meg evoked each addl	3.49	5.23	$173.00	$187.22	-7.6%
95970	Hospital	Alys npgt w/o prgrmg	0.35	0.53	$17.53	$19.03	-7.9%
95970	Office	Alys npgt w/o prgrmg	0.35	0.54	$17.86	$19.38	-7.8%
95971	Hospital	Alys smpl sp/pn npgt w/prgrm	0.78	1.17	$38.70	$40.49	-4.4%
95971	Office	Alys smpl sp/pn npgt w/prgrm	0.78	1.44	$47.63	$49.83	-4.4%
95972	Hospital	Alys cplx sp/pn npgt w/prgrm	0.80	1.19	$39.36	$41.18	-4.4%
95972	Office	Alys cplx sp/pn npgt w/prgrm	0.80	1.68	$55.57	$57.10	-2.7%
95976	Hospital	Alys smpl cn npgt prgrmg	0.73	1.16	$38.37	$40.49	-5.2%
95976	Office	Alys smpl cn npgt prgrmg	0.73	1.18	$39.03	$41.18	-5.2%
95977	Hospital	Alys cplx cn npgt prgrmg	0.97	1.54	$50.94	$53.29	-4.4%
95977	Office	Alys cplx cn npgt prgrmg	0.97	1.57	$51.93	$54.33	-4.4%
95983	Hospital	Alys brn npgt prgrmg 15 min	0.91	1.46	$48.29	$50.87	-5.1%
95983	Office	Alys brn npgt prgrmg 15 min	0.91	1.49	$49.29	$51.91	-5.1%
95984	Hospital	Alys brn npgt prgrmg addl 15	0.80	1.28	$42.34	$44.64	-5.2%
95984	Office	Alys brn npgt prgrmg addl 15	0.80	1.30	$43.00	$45.33	-5.1%

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Payment Rates for Medicare Physician Services - Epilepsy Surgery							
CPT Code	Mod	Descriptor	2023			2022	% payment change 2022 to 2023
			Work RVUs	Total RVUs	Payment CF=$33.0775	Payment CF=$34.6062	
61531		Implant brain electrodes	16.41	37.70	$1,247.02	$1,263.13	-1.3%
61534		Removal of brain lesion	23.01	50.71	$1,677.36	$1,701.24	-1.4%
61536		Removal of brain lesion	37.72	78.92	$2,610.48	$2,648.07	-1.4%
61537		Removal of brain tissue	36.45	75.20	$2,487.43	$2,524.18	-1.5%
61538		Removal of brain tissue	39.45	81.40	$2,692.51	$2,731.12	-1.4%
61539		Removal of brain tissue	34.28	72.33	$2,392.50	$2,426.93	-1.4%
61540		Removal of brain tissue	31.43	66.71	$2,206.60	$2,237.98	-1.4%
61541		Incision of brain tissue	30.94	65.93	$2,180.80	$2,210.99	-1.4%
61543		Removal of brain tissue	31.31	66.62	$2,203.62	$2,235.21	-1.4%
61566		Removal of brain tissue	32.45	68.64	$2,270.44	$2,304.08	-1.5%
61567		Incision of brain tissue	37.00	78.19	$2,586.33	$2,623.50	-1.4%
61720		Incise skull/brain surgery	17.62	39.10	$1,293.33	$1,311.23	-1.4%
61735		Incise skull/brain surgery	22.35	49.02	$1,621.46	$1,644.49	-1.4%
61750		Incise skull/brain biopsy	19.83	43.21	$1,429.28	$1,451.73	-1.5%
61751		Brain biopsy w/ct/mr guide	18.79	42.63	$1,410.09	$1,428.54	-1.3%
61760		Implant brain electrodes	22.39	48.72	$1,611.54	$1,634.80	-1.4%
61770		Incise skull for treatment	23.19	49.78	$1,646.60	$1,670.44	-1.4%
61790		Treat trigeminal nerve	11.60	27.20	$899.71	$912.57	-1.4%
61791		Treat trigeminal tract	15.41	34.69	$1,147.46	$1,162.77	-1.3%
61796		Srs, cranial lesion simple	13.93	31.29	$1,034.99	$1,048.57	-1.3%
61797		Srs, cran les simple, addl	3.48	6.67	$220.63	$223.90	-1.5%
61798		Srs, cranial lesion complex	19.85	42.32	$1,399.84	$1,420.24	-1.4%
61799		Srs, cran les complex, addl	4.81	9.19	$303.98	$309.03	-1.6%
61736		Litt icr 1 traj 1 smpl les	19.06	26.60	$879.86	$924.68	-4.8%
61737		Litt icr mlt trj mlt/cplx ls	22.67	31.79	$1,051.53	$1,101.52	-4.5%
61800		Apply srs headframe add-on	2.25	4.59	$151.83	$155.04	-2.1%
61867		Implant neuroelectrode	33.03	69.88	$2,311.46	$2,342.15	-1.3%
61868		Implant neuroelectrde, add'l	7.91	15.17	$501.79	$509.06	-1.4%
61880		Revise/remove neuroelectrode	6.95	18.06	$597.38	$605.61	-1.4%
61885		Insrt/redo neurostim 1 array	6.05	16.17	$534.86	$542.63	-1.4%
61886		Implant neurostim arrays	9.93	26.97	$892.10	$902.88	-1.2%
61888		Revise/remove neuroreceiver	5.23	12.25	$405.20	$411.81	-1.6%
63620		Srs, spinal lesion	15.60	34.58	$1,143.82	$1,157.23	-1.2%
63621		Srs, spinal lesion, addl	4.00	7.68	$254.04	$257.47	-1.3%

2023 Proposed Physician Fee Schedule (CMS–1770–P)										
Payment Rates for Medicare Physician Services - Evaluation and Management										
CPT Code	Descriptor	2023	NON-FACILITY (OFFICE)				FACILITY (HOSPITAL)			
			2023		2022	% payment change 2022 to 2023	2023		2022	% payment change 2022 to 2023
		Work RVUs	Total RVUs	Payment CF=$33.0775	Payment CF=$34.6062		Total RVUs	Payment CF=$33.0775	Payment CF=$34.6062	
99202	Office o/p new sf 15-29 min	0.93	2.16	$71.45	$74.06	-3.5%	1.43	$47.30	$49.49	-4.4%
99203	Office o/p new low 30-44 min	1.60	3.32	$109.82	$113.85	-3.5%	2.44	$80.71	$84.44	-4.4%
99204	Office o/p new mod 45-59 min	2.60	4.97	$164.40	$169.57	-3.0%	3.96	$130.99	$136.69	-4.2%
99205	Office o/p new hi 60-74 min	3.50	6.54	$216.33	$224.25	-3.5%	5.39	$178.29	$185.49	-3.9%
99211	Office o/p est minimal prob	0.18	0.69	$22.82	$23.53	-3.0%	0.26	$8.60	$9.00	-4.4%
99212	Office o/p est sf 10-19 min	0.70	1.66	$54.91	$57.45	-4.4%	1.04	$34.40	$36.68	-6.2%
99213	Office o/p est low 20-29 min	1.30	2.68	$88.65	$92.05	-3.7%	1.95	$64.50	$67.48	-4.4%
99214	Office o/p est mod 30-39 min	1.92	3.80	$125.69	$129.77	-3.1%	2.88	$95.26	$98.97	-3.8%
99215	Office o/p est hi 40-54 min	2.80	5.34	$176.63	$183.07	-3.5%	4.25	$140.58	$147.08	-4.4%
99221	Initial hospital care	1.63	NA	NA	NA	NA	2.45	$81.04	$100.70	-19.5%
99222	Initial hospital care	2.60	NA	NA	NA	NA	3.86	$127.68	$135.31	-5.6%
99223	Initial hospital care	3.50	NA	NA	NA	NA	5.17	$171.01	$198.29	-13.8%
99231	Subsequent hospital care	1.00	NA	NA	NA	NA	1.46	$48.29	$38.76	24.6%
99232	Subsequent hospital care	1.59	NA	NA	NA	NA	2.35	$77.73	$71.29	9.0%
99233	Subsequent hospital care	2.40	NA	NA	NA	NA	3.50	$115.77	$102.43	13.0%
99291	Critical care first hour	4.50	8.19	$270.90	$282.39	-4.1%	6.37	$210.70	$219.06	-3.8%
99292	Critical care addl 30 min	2.25	3.57	$118.09	$123.20	-4.1%	3.19	$105.25	$110.05	-4.4%
99421	Ol dig e/m svc 5-10 min	0.25	0.44	$14.55	$15.23	-4.4%	0.38	$12.57	$13.15	-4.4%
99422	Ol dig e/m svc 11-20 min	0.50	0.85	$28.12	$29.76	-5.5%	0.73	$24.15	$25.95	-7.0%
99423	Ol dig e/m svc 21+ min	0.80	1.38	$45.65	$48.45	-5.8%	1.18	$39.03	$41.87	-6.8%
99446	Interprof phone/online 5-10	0.35	0.51	$16.87	$18.69	-9.7%	0.51	$16.87	$18.69	-9.7%
99447	Interprof phone/online 11-20	0.70	1.06	$35.06	$36.68	-4.4%	1.06	$35.06	$36.68	-4.4%
99448	Interprof phone/online 21-30	1.05	1.58	$52.26	$55.02	-5.0%	1.58	$52.26	$55.02	-5.0%
99449	Interprof phone/online 31/>	1.40	2.14	$70.79	$73.71	-4.0%	2.14	$70.79	$73.71	-4.0%
99451	Ntrprof ph1/ntrnet/ehr 5/>	0.70	1.06	$35.06	$36.34	-3.5%	1.06	$35.06	$36.34	-3.5%
99452	Ntrprof ph1/ntrnet/ehr rfrl	0.70	0.97	$32.09	$37.03	-13.3%	0.97	$32.09	$37.03	-13.3%
99453	Rem mntr physiol param setup	0.00	0.57	$18.85	$19.03	-1.0%	NA	NA	NA	NA
99454	Rem mntr physiol param dev	0.00	1.48	$48.95	$55.72	-12.1%	NA	NA	NA	NA
99457	Rem physiol mntr 20 min mo	0.61	1.43	$47.30	$50.18	-5.7%	0.88	$29.11	$31.15	-6.5%
99458	Rem physiol mntr ea addl 20	0.61	1.16	$38.37	$40.84	-6.0%	0.88	$29.11	$31.15	-6.5%
99471	Ped critical care initial	15.98	NA	NA	NA	NA	22.95	$759.13	$793.87	-4.4%
99472	Ped critical care subsq	7.99	NA	NA	NA	NA	11.66	$385.68	$404.89	-4.7%
99487	Cmplx chron care w/o pt vsit	1.81	3.94	$130.33	$134.27	-2.9%	2.69	$88.98	$92.74	-4.1%
99489	Cmplx chron care addl 30 min	1.00	2.08	$68.80	$70.60	-2.5%	1.48	$48.95	$51.22	-4.4%
99490	Chron care mgmt srvc 20 min	1.00	1.85	$61.19	$64.02	-4.4%	1.49	$49.29	$51.56	-4.4%
99491	Chrnc care mgmt svc 30 min	1.50	2.49	$82.36	$86.17	-4.4%	2.23	$73.76	$77.52	-4.8%
99495	Trans care mgmt 14 day disch	2.78	6.05	$200.12	$209.02	-4.3%	4.12	$136.28	$144.65	-5.8%
99496	Trans care mgmt 7 day disch	3.79	8.20	$271.24	$281.69	-3.7%	5.63	$186.23	$195.87	-4.9%
G0396	Alcohol/subs interv 15-30mn	0.65	1.04	$34.40	$35.99	-4.4%	0.94	$31.09	$32.88	-5.4%
G0397	Alcohol/subs interv >30 min	1.30	2.02	$66.82	$69.21	-3.5%	1.93	$63.84	$66.10	-3.4%
G0506	Comp asses care plan ccm svc	0.87	1.81	$59.87	$62.64	-4.4%	1.29	$42.67	$45.33	-5.9%
GXXX1	Prolong hosp inpt each ad 15m	0.61	0.93	$30.76	NA	NA	0.89	$29.44	NA	NA

A.3 Optimal Care for Patients with Episodic Neurological Conditions MVP

The proposed Optimal Care for Patients with Episodic Neurological Conditions MVP focuses on the clinical theme of promoting quality care for patients suffering from episodic neurological conditions. This proposed MVP would be most applicable to clinicians who treat patients within the practice of neurology.

Quality Measures

We propose to include four MIPS quality measures and six QCDR measures within the quality component of this MVP, which focus on a variety of neurological conditions that may impact patient health. We reviewed the MIPS quality measure inventory and believe the following quality measures would provide a meaningful and comprehensive assessment of the clinical care for clinicians who specialize in treating patients with episodic neurological conditions:

- Q268: Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy: This MIPS quality measure assesses patients, that are diagnosed with epilepsy and are of child-bearing age, to ensure they receive counseling regarding how the treatment of epilepsy may affect contraception and pregnancy.
- Q419: Overuse of Imaging for the Evaluation of Primary Headache: This MIPS quality measure assesses overuse of the head (CT or MRI) for the evaluation of primary headache.
- AAN5: Medication Prescribed for Acute Migraine Attack: This QCDR measure assesses pediatric and adult patients diagnosed with migraine that were prescribed a guideline recommended or FDA approved/cleared treatment for acute migraine attacks.
- AAN22: Quality of Life Outcome for Patients with Neurologic Conditions: This QCDR measure evaluates performance outcomes for patients with neurologic conditions. The outcomes from these assessments should reflect an improvement or maintenance of a patient's perceived quality of life. This measure includes patients diagnosed with the following neurologic conditions: amyotrophic lateral sclerosis, attention deficit disorders, autism, cerebral palsy, cognitive impairment and related dementias, developmental delays, headache and migraine, movement disorders, multiple sclerosis, muscular dystrophy, neoplasms of brain and spine, polyneuropathy, seizure and epilepsy, stroke, tic disorders, vertigo, and related neuro-otology disorders.
- AAN29: Comprehensive Epilepsy Care Center Referral or Discussion for Patients with Epilepsy: This QCDR measure assesses for patients that had referrals or a discussion of evaluation at a comprehensive epilepsy care center.
- AAN30: Migraine Preventive Therapy Management: This QCDR measure assesses pediatric and adult patients diagnosed with migraine, that occur with a frequency is greater than or equal to 6 days per month/4 attacks per month, receive evidence-based preventive migraine therapy, including therapies prescribed by another clinician.
- AAN31: Acute Treatment Prescribed for Cluster Headache: This QCDR measure ensures patients diagnosed with cluster headache were prescribed an acute treatment, including treatments prescribed by a different clinician.
- AAN32: Preventive Treatment Prescribed for Cluster Headache: This QCDR measure ensures patients diagnosed with cluster headache were prescribed short-term and/or long-term preventive treatment, including treatments prescribed by a different clinician.

In conjunction with the aforementioned neurological measures, we propose to include the following broadly applicable MIPS quality measures that are relevant to neurological conditions. The quality measures below encourage advance care planning and documentation of current medications, which capture the patient's voice and supports safety for patients that are experiencing episodic neurological conditions:

- Q047: Advance Care Plan: This MIPS quality measure captures the clinical interaction of documenting a patient's voice for possible, future life-sustaining medical intervention. This engagement between the clinician (or clinician staff) and the patient allows the patient to be autonomous and communicate their ideal of clinical care that ensures coordinated care is implemented as documented in the patient's medical record.
- Q130: Documentation of Current Medications in the Medical Record: This MIPS quality measure bases performance on clinicians documenting the list of current medications using all immediate resources for capture of this important clinical topic.

Improvement Activities

Within the improvement activities component of this MVP, we propose to include fourteen improvement activities that reflect actions and processes undertaken by clinicians who provide neurological care to patients, as well as activities that promote patient engagement and patient-centeredness, health equity, shared decision making, and care coordination. These improvement activities provide opportunities for clinicians, in collaboration with patients, to drive outcomes and improve quality of care for patients needing neurological care. The following improvement activities are proposed for inclusion in this MVP:

- IA_AHE_3: Promote Use of Patient-Reported Outcome Tools
- IA_BE_4: Engagement of patients through implementation of improvements in patient portal
- IA_BE_16: Promote Self-management in Usual Care
- IA_BE_24: Financial Navigation Program
- IA_BMH_4: Depression screening
- IA_BMH_8: Electronic Health Record Enhancements for BH data capture
- IA_CC_1: Implementation of use of specialist reports back to referring clinician or group to close referral loop
- IA_EPA_1: Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record
- IA_EPA_2: Use of telehealth services that expand practice access
- IA_PCMH: Electronic submission of Patient Centered Medical Home accreditation
- IA_PM_11: Regular review practices in place on targeted patient population needs

- IA_PM_16: Implementation of medication management practice improvements
- IA_PM_21: Advance Care Planning
- IA_PSPA_21: Implementation of fall screening and assessment programs

Cost Measures

Within the cost component of this MVP, we propose to include the Medicare Spending Per Beneficiary (MSPB) Clinician measure because it applies to clinicians providing care in inpatient hospitals, including care for patients with neurological conditions. This is in line with the intent of the MVP. Currently, there are no applicable episode-based measures available, but one could be considered for development in the future.

TABLE A.3: Optimal Care for Patients with Episodic Neurological Conditions MVP

As noted in the introduction of this appendix, we considered measures and improvement activities available within the MIPS inventory and selected those that we determined best fit the clinical concept of the proposed Optimal Care for Patients with Episodic Neurological Conditions MVP. We request comment on the measures and activities included in this MVP.

Quality	Improvement Activities	Cost
(!) Q047: Advance Care Plan (Collection Type: Medicare Part B Claims Measure Specifications, MIPS CQMs Specifications) **(*)(!) Q130:** Documentation of Current Medications in the Medical Record (Collection Type: Medicare Part B Claims Measure Specifications, eCQM Specifications, MIPS CQMs Specifications) **Q268:** Epilepsy: Counseling for Women of Childbearing Potential with Epilepsy (Collection Type: MIPS CQMs Specifications) **(!) Q419:** Overuse of Imaging for the Evaluation of Primary Headache (Collection Type: MIPS CQMs Specifications) **(#) AAN5:** Medication Prescribed for Acute Migraine Attack (Collection Type: QCDR) **(#)(!)(!!) AAN22:** Quality of Life Outcome for Patients with Neurologic Conditions (Collection Type: QCDR) **(#) AAN29:** Comprehensive Epilepsy Care Center Referral or Discussion for Patients with Epilepsy (Collection Type: QCDR) **(#) AAN30:** Migraine Preventive Therapy Management (Collection Type: QCDR) **(#) AAN31**: Acute Treatment Prescribed for Cluster Headache (Collection Type: QCDR) **(#) AAN32:** Preventive Treatment Prescribed for Cluster Headache (Collection Type: QCDR)	**(~) IA_AHE_3:** Promote Use of Patient-Reported Outcome Tools (High) **IA_BE_4:** Engagement of patients through implementation of improvements in patient portal (Medium) **IA_BE_16:** Promote Self-management in Usual Care (Medium) **IA_BE_24:** Financial Navigation Program (Medium) **IA_BMH_4:** Depression screening (Medium) **IA_BMH_8:** Electronic Health Record Enhancements for BH data capture (Medium) **IA_CC_1:** Implementation of use of specialist reports back to referring clinician or group to close referral loop (Medium) **(~) IA_EPA_1:** Provide 24/7 Access to MIPS Eligible Clinicians or Groups Who Have Real-Time Access to Patient's Medical Record (High) **(~) IA_EPA_2:** Use of telehealth services that expand practice access (Medium) **(%) IA_PCMH:** Electronic submission of Patient Centered Medical Home accreditation **(~) IA_PM_11:** Regular review practices in place on targeted patient population needs (Medium) **IA_PM_16:** Implementation of medication management practice improvements (Medium) **IA_PM_21:** Advance Care Planning (Medium) **IA_PSPA_21:** Implementation of fall screening and assessment programs (Medium)	**Medicare Spending Per Beneficiary (MSPB) Clinician**
Foundational Layer		

Population Health Measures	Promoting Interoperability
(!!) Q479: Hospital-Wide, 30-Day, All-Cause Unplanned Readmission (HWR) Rate for the Merit-Based Incentive Payment Systems (MIPS) Eligible Clinician Groups (Collection Type: Administrative Claims) **(!!) Q484:** Clinician and Clinician Group Risk-standardized Hospital Admission Rates for Patients with Multiple Chronic Conditions (Collection Type: Administrative Claims)	Security Risk Analysis Safety Assurance Factors for EHR Resilience Guide (SAFER Guide) e-Prescribing **(*)** Query of the Prescription Drug Monitoring Program (PDMP) Provide Patients Electronic Access to Their Health Information Support Electronic Referral Loops By Sending Health Information AND Support Electronic Referral Loops By Receiving and Reconciling Health Information **OR** Health Information Exchange (HIE) Bi-Directional Exchange OR **(^)** Enabling Exchange Under the Trusted Exchange Framework and Common Agreement (TEFCA) Immunization Registry Reporting Syndromic Surveillance Reporting (Optional) Electronic Case Reporting Public Health Registry Reporting (Optional) Clinical Data Registry Reporting (Optional) Actions to Limit or Restrict Compatibility or Interoperability of CEHRT ONC Direct Review