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CME

The 2023 CPT Coding and Medicare Payment Update

There are a host of changes that will affect family physicians, including new vaccine codes and bundled Medicare payments for chronic pain management.

As the new year begins, it's time to get familiar with the 2023 changes to CPT coding, Medicare payment policies, and Medicare's Quality Payment Program (QPP).

There are a host of coding changes, including substantial revisions to evaluation and management (E/M) services that occur in hospitals or nursing homes, and changes to how prolonged services can be reported. The most concerning Medicare payment policy is a reduction in the overall payment rate under the physician fee schedule unless Congress intervenes. Medicare is also rolling out new bundled coding and payment options for chronic

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pain management and expanding the list of services that can be provided via telehealth. The changes to QPP are small this year, but noteworthy nonetheless. Now, let's get into the details.

E/M CODING

There are changes to E/M coding on several fronts, as CPT follows up on the office and outpatient E/M visit reforms of 2021.[1]

Hospital and nursing home visits. The most consequential changes to E/M coding this year come in hospital and nursing home settings, which have moved to the same code level selection criteria as office/outpatient E/M services. Physicians will now select codes for these services based on either their total time spent caring for the patient or their level of medical decision making (MDM). The same MDM table CPT used for office-based E/M codes will now be used for hospital and nursing home E/M services, with a few revisions from CPT:[2]

- Added "1 stable acute illness" and "1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care" to the low-level MDM elements in the problems category,
- Added decisions regarding the "escalation of hospital-level of care" and "parenteral controlled substances" to the high-level MDM elements in the risk category,
- Added "multiple morbidities requiring intensive management" to the risk category, but this applies only to initial nursing facility visits.

Other CPT changes also impact how you will report these services. For 2023, CPT has done the following:

- Consolidated hospital inpatient and observation codes into a single family of codes: 99221-99223 and 99231-99233,
- Redefined the lowest level of emergency department codes (99281) to describe visits that do not require a physician or other qualified health care professional (much like office-visit code 99211),
- Deleted the separate code for nursing home annual exams, which will now be coded as subsequent nursing home visits (99307-99310),
- Consolidated the category "Domiciliary, Rest Home (e.g., Boarding Home), or Custodial Care Services" into a new category called "Home or Residence Services."

For more on these changes, and how physicians can use them to code hospital and nursing home visits more quickly, see "The 2023 Hospital and Nursing Home E/M Visit Coding Changes" on page 8.

Multiple E/M services on the same day. CPT has also revised its guidelines for hospital E/M to allow the reporting of multiple services when a patient is admitted to inpatient or observation status during a visit at another site of service (e.g., office or emergency department). The CPT guidelines advise clinicians to append modifier 25 to the initial service and then also report the hospital-based service (no modifier required on that). However, the Centers for Medicare & Medicaid Services (CMS) is retaining its policy that clinicians should only report one service (the hospital visit) per calendar date in these situations. It remains to be seen whether non-Medicare payers will follow CPT's guidance or Medicare's.

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Prolonged services. CPT has deleted the codes for prolonged E/M services with direct patient contact in the office (99354-99355) and inpatient (99356-99357) settings. Physicians have been able to use code 99417 (in conjunction with 99205 or 99215) to report prolonged services in the office setting since the 2021 changes, and that will now be the only option there. Meanwhile, a new code, 99418, will be used for prolonged

KEY POINTS

- In addition to significant changes to hospital and nursing home evaluation and management coding, 2023 brings several changes to vaccine administration and remote monitoring coding.
- Medicare is cutting the amount it pays per relative value unit by 4.5% (barring Congressional action), revising certain telehealth policies, and creating bundled payments for chronic pain management.
- Changes to the Quality Payment Program in 2023 are minimal.

services in hospitals and nursing homes.

CPT guidance allows clinicians to report 99417 and 99418, along with a primary E/M code for the highest level of service in each setting, once they surpass the *minimum* time of the highest level of service by 15 minutes. But this is another area where CPT and Medicare differ. Medicare requires clinicians to surpass the *maximum* time of the highest E/M level by 15 minutes before reporting prolonged services codes. As such, CMS has developed its own HCPCS codes to report prolonged services to Medicare when those conditions are met:

- G2212, prolonged services for office or other outpatient services,
- G0316, prolonged services for inpatient and observation care services,
- G0317, prolonged services for nursing facility services,
- G0318, prolonged services for home/residence services.

CPT is maintaining two of its previous prolonged services codes — 99358 and 99359 — for reporting non-face-to-face services that occur on a different date than the face-to-face visit. But those codes are revised, with their headings changing from "Prolonged evaluation and management service before and/or after direct patient care" to "Prolonged service on date other than the face-to-face evaluation and management service without direct patient contact."

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OTHER CPT CHANGES

In addition to the E/M changes, there are a number of other CPT revisions family physicians may want to take note of.

Remote therapeutic monitoring (98975-98978). CPT has revised the description for remote therapeutic monitoring code 98975 to accommodate the addition of a new CPT code, 98978, specifically for monitoring for cognitive behavioral therapy. (The description's parenthetical section now includes only "therapy adherence" and "therapy response." References to respiratory and musculoskeletal systems have been removed.) As with remote monitoring codes 98976 and 98977, clinicians will use code 98978 once per 30-day monitoring period to report supplying the monitoring device to the patient for scheduled recordings and/or programmed alert transmissions.

CPT has also revised the introductory guidelines to the remote therapeutic monitoring section to recognize the new code and made changes to the introductory guidelines for remote therapeutic monitoring treatment management services to clarify the appropriate reporting of these services. There are no changes to the existing CPT codes 98980 and 98981 for remote therapeutic monitoring treatment/interactive communication.

Vaccine product and administration codes. CPT 2023 includes multiple new codes for COVID-19 vaccines and their administration. CPT also revised several codes to accommodate changes in patient ages as vaccine guidelines were updated. The codes are unique for each of the COVID-19 vaccines approved in the U.S., and administration codes are unique to each vaccine and dose. All COVID-19 vaccine codes and administration codes are listed in the vaccine section of CPT and in Appendix Q.[3]

Other new vaccine codes this year include the following:

- 90584, "Dengue vaccine, quadrivalent, live, 2 dose schedule, for subcutaneous use,"
- 90678, "Respiratory syncytial virus vaccine, preF, subunit, bivalent, for intramuscular use."

CPT has also revised code 90739 to read, "Hepatitis B vaccine (HepB), CpG-adjuvanted, adult dosage, 2 dose or 4 dose schedule, for intramuscular use." The American Medical Association maintains current information on all CPT vaccine codes on its website.[4]

Suture and staple removal. CPT created two new codes for reporting removal of sutures and/or staples not requiring anesthesia. Code +15853 is for removing either sutures or staples without anesthesia, and code +15854 is for removing *both* sutures and staples without anesthesia. Both are

add-on codes reported in addition to an E/M service (modifier 25 is *not* required on the E/M code when you report add-on codes).

Prior to 2023, CPT made a distinction between suture removal by the same physician who performed the primary procedure and suture removal by a different physician. However, CPT 2023 removed that language, and the suture-removal codes now can be reported by the physician who performed the primary procedure or another clinician.

MEDICARE PAYMENT POLICY CHANGES

CMS has set the 2023 conversion factor (i.e., the amount Medicare pays per relative value unit [RVU] under its physician fee schedule) at $33.06 — about 4.5% lower than 2022. Most of this reduction is because a 3% increase in the 2022 conversion factor that Congress applied via legislation is expiring. The remaining 1.5% reduction is due to budget neutrality adjustments that CMS must make to offset spending increases from regulatory changes that increase RVUs for some services, such as the hospital, nursing facility, and home E/M services. (If Congress acts to avoid the 4.5% cut, this article will be updated at https://www.aafp.org/pubs/fpm/issues/2023/0100/coding-update-2023.html.)

Here are other notable Medicare changes in 2023.

Chronic pain management and treatment bundles. CMS is implementing separate coding and payment for chronic pain management (CPM) services beginning Jan. 1, 2023. The agency will allow non-physician practitioners (e.g., nurse practitioners and physician assistants) to provide CPM and requires the initial visit to be face-to-face. CMS has created two HCPCS codes to report monthly CPM:

• 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 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.)"

This year we are getting a clearer picture of what Medicare telehealth services may look like after the PHE.

• 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.)"

Telehealth. CMS greatly expanded the services that can be provided via telehealth in response to the COVID-19 public health emergency (PHE). This year we are getting a clearer picture of what Medicare telehealth services may look like after the PHE.

CMS has added some services to its official telehealth list[5] on a Category 3 (temporary) basis and some on a Category 1 (permanent) basis. Category 3 additions will be on the list through the end of 2023 or 151 days after the PHE ends, whichever is later. Several emotional/behavior assessment, psychological, and neuropsychological testing and evaluation services have been added to the list as Category 3 items. The newly finalized prolonged services codes G0316-G0318 and the chronic pain management codes G3002 and G3003 are on the list as Category 1 items.

CMS will also continue to allow audio-only (i.e., telephone) services to be billed as telehealth temporarily. But following the 151-day post-PHE extension period, CMS

will once again assign the telephone E/M services (CPT codes 99441-99443) a "bundled" status, which means Medicare will no longer separately pay for them.

For allowable audio-only services, clinicians will have the option to append either Medicare modifier FQ, "Medicare telehealth service was furnished using audio-only communication technology," or CPT modifier 93, "Synchronous telemedicine service rendered via telephone or other real-time interactive audio-only telecommunications system." Clinicians will continue to use modifier FR on applicable claims when required to be present through an interactive real-time audio and video telecommunications link, as reflected in each service's requirements.

Until the end of 2023 or the end of the year in which the PHE ends (whichever comes later), clinicians should continue to append CPT modifier 95, "Synchronous telemedicine service rendered via a real-time interactive audio and video telecommunications system" and use the place of service (POS) code reflecting where the service would have been furnished had it been in-person. CMS will continue to pay at the rate corresponding to that POS, which will typically be the higher "non-facility" rate.

Other Medicare provisions of interest. CMS has updated Medicare Part B payments for administration of the influenza, pneumococcal, hepatitis B, and COVID-19 vaccines based on the annual increases to the Medicare Economic Index (MEI) and will geographically adjust the payments. The MEI is an index that measures changes in the market price of the inputs used to furnish physician services. The MEI update for 2023 is 3.8%.

CMS has reduced the minimum age for coverage of certain colorectal cancer screening tests from 50 to 45 years of age. CMS has also finalized expanded coverage of colorectal cancer screening to include a follow-on screening colonoscopy after a non-invasive stool-based test returns a positive result, thereby removing cost sharing for most beneficiaries.

QUALITY PAYMENT PROGRAM AND MEDICARE SHARED SAVINGS PROGRAM (MSSP)

Medicare's alternative payment programs are staying much the same this year, but there are a few changes to be aware of.

QPP. For the 2023 performance year, CMS is doing the following to QPP:

- Implementing Merit-based Incentive Payment System (MIPS) Value Pathways (MVPs) as a new reporting option in MIPS. There will be 12 MVPs available for clinicians to report, including two focused on primary care: promoting wellness and optimizing chronic care.
- Maintaining the performance threshold at 75 points. Eligible clinicians (ECs) will receive payment increases or reductions of up to 9% on their Medicare Part B claims, depending on how their performance compares to the threshold. There is no exceptional performer threshold in 2023.
- Maintaining category weights at the same levels: 30% quality, 30% cost, 25% improvement activities, and 15% promoting interoperability.

In the MIPS quality category, CMS is doing the following:

- Maintaining the quality data completeness criteria threshold at 70%. Beginning in 2023, the Web Interface is only available to MSSP accountable care organizations (ACOs) reporting using the Alternative Payment Model Performance Pathway.
- Expanding the definition of a high-priority measure to include health equity-related quality measures.
- Establishing a policy to score administrative claims measures against performance period benchmarks.

In the MIPS cost category, CMS is establishing a maximum cost improvement score of one percentage point. CMS began including improvement in the scoring of the cost performance category with the 2022 performance period.

In the MIPS improvement activities category, CMS made no changes except to update the inventory of activities.

In the MIPS promoting interoperability category, CMS is doing the following:

- Discontinuing automatic reweighting for nurse practitioners, physician assistants, certified registered nurse anesthetists, and clinical nurse specialists. CMS will continue to apply automatic reweighting for certain clinicians, including those in small practices.
- Modifying the options for active

engagement for the Public Health and Clinical Data Exchange Objective measures. ECs will have two options: "pre-production and validation" and "validated data production." ECs will attest yes or no and submit their level of active engagement. ECs can also only spend one performance period at the "pre-production and validation" level.

• Requiring the Query of Prescription Drug Monitoring Program measure, which is worth 10 points, with exclusions available. In addition to including schedule II drugs, CMS is expanding the measure to include schedule III and IV drugs.

• Adding a third option to satisfy the Health Information Exchange objective: "Participation in the Trusted Exchange Framework and Common Agreement (TEFCA)."

MSSP. CMS made more substantial changes to the MSSP (none of these changes apply to the ACO REACH model, which is a separate program). The changes include the following:

• Providing Advance Investment Payments (AIPs) to new entrants inexperienced with performance-based risk. AIPs will be a one-time payment of $250,000 and eight quarterly payments based on the number of beneficiaries assigned to the ACO. CMS will recoup the AIP from any shared savings earned by the ACO in its current agreement period.

• Allowing ACOs inexperienced with performance-based risk to remain in the Basic track level A for all five years of the agreement period.

• Making the Enhanced track optional for everyone.

• Reinstating a sliding scale to determine shared savings for ACOs that failed to meet the criteria under the quality performance standard to qualify for the maximum shared savings rate. CMS will use a similar policy to determine an ACO's shared loss rate in the Enhanced track for ACOs that exceed the maximum loss rate. To qualify for the sliding scale, the ACO must achieve a score in the 10th percentile or higher for at least one of the four outcome measures in the APM Performance Pathway.

• Establishing a health equity adjustment of up to 10 bonus points applied to MIPS quality performance scores for ACOs that report the three electronic clinical quality measures or MIPS clinical quality measures.

• Updating the benchmarking methodology to include an administrative growth factor, reinstituting an adjustment for prior savings, and reducing the cap on negative regional adjustments.

• Allowing certain ACOs in the basic track that do not meet the minimum shared savings rate to qualify for shared savings if the ACO meets the quality standard (including the alternative standard).

This is a high-level list of the most important changes family physicians need to know about as the year begins.

A PLACE TO START

These are not all the updates to the Medicare physician fee schedule, QPP, or CPT codes for 2023. But this is a high-level list of the most important changes family physicians need to know about as the year begins. As always, how individual payers approach these coding and payment changes may vary, so you're advised to consult with those in your area to find out how they will handle them. FPM

1. Millette KW. Countdown to the E/M coding changes. *Fam Pract Manag.* 2020;27(5):29-36.

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3. Appendix Q: severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccines. American Medical Association. Accessed Dec. 2, 2022. https://www.ama-assn.org/system/files/covid-19-immunizations-appendix-q-table.pdf

4. Category I vaccine codes. American Medical Association. Updated Nov. 16, 2022. Accessed Dec. 2, 2022. https://www.ama-assn.org/practice-management/cpt/category-i-vaccine-codes

5. List of telehealth services. Centers for Medicare & Medicaid Services. Updated Nov. 2, 2022. Accessed Dec. 2, 2022. https://www.cms.gov/medicare/medicare-general-information/telehealth/telehealth-codes

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