# 2023 Medicare Physician Fee Schedule (MPFS) Final Rule Webinar

## December 1, 2022
## Webinar FAQ Document

1. **Question** – The August 2022 CPT® Assistant says that evaluation and management (E/M) visits based on time or medical decision making (MDM) does not apply to Emergency Department (ED) visits. Are there any updates?

   Answer – Effective January 1, 2023, the descriptions for all five Current Procedural Terminology (CPT®) codes for emergency department (ED) visits will be changing. The new descriptions will indicate that the ED visit should include a medically appropriate history and/or examination, and code selection would be based on the level of medical decision making (MDM). Here is an example of the difference, using CPT® code 99283:

   2022 description: *Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.*

   2023 description: *Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and low level of medical decision making.*

2. **Question** – Regarding the ED level changes, does this/should this change how the facility bills ED levels?

   Answer – Hospitals are still instructed to use internally developed criteria for the assignment of Emergency Room Evaluation and Management (E/M) levels. The description revisions made to the Emergency Room E/M codes (99281-99285) for CY 2023 do not impact facility selection of E/M level.

3. **Question** – What if the ED physician admits the patient on behalf of another provider? Does the ED provider report the initial inpatient codes or the ED codes?

   Answer – This topic was not discussed in the MPFS Final Rule. According to the Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners, the patient may be admitted from the ED; however, only one E/M service is reportable. The provider would not be allowed to report both an ED visit and the hospital admission service.[1]

[1] Pub. 100-04 Medicare Claims Processing Manual, Chapter 12 Physicians/Nonphysician Practitioners, Subsection 30.6.9.1 Payment for Initial Hospital Care Services and Observation or Inpatient Care Services

4. **Question** – The patient is seen in the ED for an injury. The ED provides care and reports an ED E/M visit. During the encounter, the ED physician determines to also consult psych services. The psych provider evaluates the patient and reports 99245. The psych provider well exceeds the time allocated for the outpatient consultation (75 minutes). Can the psych provider report CPT® 99245 *Office or other outpatient consultation for a new or established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using total time on the date of the encounter for code selection, 55 minutes must be met or exceeded* and CPT® 99417 *Prolonged outpatient evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the outpatient Evaluation and Management service)* when the services are provided in the ED? The psych provider is seeing the patient in the ED due to lack of facility/observation floor beds.

   Answer – The psych provider would need to be able to report E/M services, so would need to be a physician or nonphysician practitioner (NPP). A provider such as a clinical psychologist or clinical social worker is not able to report E/M services. For your scenario where 75 minutes is spent providing service to the patient, you may report one unit each of 99245 and 99417. In the CPT® 2023 Manual, Professional Edition, there is a table on page 30 which contains this information.[2]

5. **Question** – Should the key components really remain the history, physical examination and medical decision making (MDM), when MDM is really the only component required in 2023?

   Answer – For Shared/Split visits, the Centers for Medicare & Medicaid Services (CMS) did not finalize any changes to their definition of the "substantive portion" of the visit. For 2023, CMS indicates that providers may use one of those three key components or time to define "substantive". CMS is taking comments and should provide an update in the calendar year (CY) 2024 MPFS Final Rule.[3]

6. **Question** – For prolonged services, I thought the outpatient Healthcare Common Procedure Coding System (HCPCS) code was G2212? Is this not correct? If yes, could this code be billed by the facility and what would the time threshold be?

   Answer – HCPCS code G2212 *Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total 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 99205, 99215 for office or other outpatient evaluation and management services) (Do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (Do not report G2212 for any time unit less than 15 minutes)* is reportable with office outpatient visits. The parenthetical notes for code G2212 indicate that

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(Including Admission and Discharge Services), "A. Initial Hospital Care From Emergency Room", page 43, available at: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

[2] CPT® 2023 Manual, Professional Edition, "Evaluation and Management / Prolonged Services," page 30

[3] Federal Register, Vol. 87, No. 222, November 18, 2022, page 61694, available at: https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

it should be reported with CPT® codes 99205 or 99215. Facilities assign E/M levels using internal guidelines that do not use time as a component, so this code would not be reported by facilities.

HCPCS code G0316 *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 G0316 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418, 99415, 99416). (Do not report G0316 for any time unit less than 15 minutes)* may be reported with inpatient or observation care services.

HCPCS code G0317 *Prolonged nursing facility 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 99306, 99310 for nursing facility evaluation and management services). (Do not report G0317 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99418). (Do not report G0317 for any time unit less than 15 minutes)* is to report prolonged services in a nursing facility.

HCPCS code G0318 *Prolonged home or residence 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 99345, 99350 for home or residence evaluation and management services). (Do not report G0318 on the same date of service as other prolonged services for evaluation and management 99358, 99359, 99417). (Do not report G0318 for any time unit less than 15 minutes)* is to be used with home or residence E/M codes.

The application of the codes is dependent upon the time listed within the CPT® code for the primary E/M service. This may vary by CPT® code.

Table 24 Required Time Thresholds to Report Other E/M Prolonged Services provides the following information:[4]

| Primary E/M Service | Prolonged Code | Time Threshold to Report Prolonged |
|---|---|---|
| Initial IP/Obs. Visit (99223) | G0316 | 105 minutes |
| Subsequent IP/Obs. Visit (99233) | G0316 | 80 minutes |
| IP/Obs. Same-Day Admission/Discharge (99236) | G0316 | 125 minutes |
| IP/Obs. Discharge Day Management (99238-9) | N/A | N/A |
| Emergency Department Visits | N/A | N/A |

[4] Federal Register, Vol. 87, No. 222, November 18, 2022, page 61694, available at: https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

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|---|---|---|
| Initial NF Visit (99306) | G0317 | 95 minutes |
| Subsequent NF Visit (99310) | G0317 | 85 minutes |
| NF Discharge Day Management | N/A | N/A |
| Home/Residence Visit New Pt (99345) | G0318 | 140 minutes |
| Home/Residence Visit Estab. Pt (99350) | G0318 | 110 minutes |
| Cognitive Assessment and Care Planning (99483) | G2212 | 100 minutes |
| Consults | N/A | N/A |

7. **Question** – Is there a limit on how many 99418 units can be used with 99223?

   Answer – The Medically Unlikely Edit (MUE) values for CPT® code 99418 *Prolonged inpatient or observation evaluation and management service(s) time with or without direct patient contact beyond the required time of the primary service when the primary service level has been selected using total time, each 15 minutes of total time (List separately in addition to the code of the inpatient and observation Evaluation and Management service)* is 4 units.

   The MUE Adjudication Indicator (MAI) is 3, meaning it is a date of service edit based on clinical benchmarks. One good feature for services assigned the MAI 3 is that you may appeal the denial when the units are exceeded.[5]

8. **Question** – Is it true that hospitals will not be able to report telehealth services after the public health emergency (PHE) ends?

   Answer – At the end of the COVID-19 PHE and the 151-day extension allowed by the Consolidated Appropriations Act, 2021 (CAA), the waivers and flexibilities end. Telehealth service reporting by facilities has been part of the "waivers and flexibilities" allowed during the PHE. After the 151-day extension ends, regulations will revert to pre-pandemic definitions.

   At that time, CMS will expect that telehealth services will be professional services only. Facilities may report Healthcare Common Procedure Coding System (HCPCS) code Q3014 *Telehealth originating site facility fee* when the facility meets the definition of an originating site. CMS expects that services would be submitted on the professional, not the institutional, form.[6]

9. **Question** – I'm a little confused about telehealth after the PHE ends, and the originating site is supposed to revert to pre-pandemic guidelines. But then it was mentioned that place of service 10 is an exception. Will the originating site be able to be the patient's home?

[5] National Correct Coding Initiative Policy Manual, Chapter 1 General Correct Coding Policies "V. Medically Unlikely Edits (MUEs)", page 27 available at: https://www.cms.gov/files/document/medicare-ncci-policy-manual-2023-chapter-1.pdf (December 1, 2022)

[6] Federal Register, Vol. 87, No. 222, November 18, 2022, page 69464, available at: https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

Answer – Last year, a new policy was established to expand access for mental health services in order to meet the needs of Medicare beneficiaries. The expansion states that mental health conditions, substance use disorders, co-occurring mental health and substance use disorders, and clinical assessments for patients with End Stage Renal Disease (ESRD) that are receiving home dialysis are the appropriate patient populations where the exception for the pre-pandemic regulations would apply.

For these services, place of service (POS) 10 *Telehealth Provided in Patient's Home* would be appropriate when telehealth services are provided to this subset of patients.[7]

10. **Question** – Is the FR modifier appended for all services provided for direct supervision through two-way audio video communication or is this only for mental health services through telehealth?

    Answer – Modifier FR *A supervising practitioner was present through a real-time two-way, audio/video communication technology* was effective January 1, 2022, and is for telehealth mental health services. With the COVID-19 PHE flexibilities and waivers allowing for services provided via audio/video communication to be reported as if the services were performed face-to-face, the modifier may only have been utilized when direct supervision was required for the service.[8]

11. **Question** – After the PHE, how would we expect to use modifier FR?

    **Answer** – In 2023, mental health supervision will be general supervision, which should expand the availability of mental health providers. In the 2023 MPFS Final Rule, CMS said that providers whose state scope of practice laws did not designate that they may provide mental health services must practice under direct supervision. In these circumstances, modifier FR will apply.[9]

12. **Question** – For the supervision update for behavioral health services, what is included as a licensed professional counselor (LPC)? Does this include Licensed Mental Health Counselors (LMHPs) or Licensed Masters of Social Workers (LMSWs)?

    Answer – Within the revisions to the "incident to" a physician's or nonphysician practitioner's (NPP's) services, CMS stated they would default to the individual state scope of practice regulations. Where the state scope of practice regulations indicate that the provider may perform mental health or behavioral health services, then the services may be provided under "general" supervision. If the state scope of practice regulations do not stipulate the provider may perform mental health or behavioral health services, then direct supervision will apply.

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[7] Federal Register, Vol. 87, No. 222, November 18, 2022, page 69464, available at: https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

[8] MLN Matters® Article MM12549, "CY2022 Telehealth Update Medicare Physician Fee Schedule", page 2, available at: https://www.cms.gov/files/document/mm12549-cy2022-telehealth-update-medicare-physician-fee-schedule.pdf (January 14, 2022)

[9] Federal Register, Vol. 87, No. 222, November 18, 2022, page 69545, available at: https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

An MSW may obtain their own provider number under Medicare and would not need to provide their services under the "incident to" provisions.[10]

13. **Question** – Is the new Behavioral Health Integration (BHI) code time-based? Will time need to be documented in the chart?

    Answer – Yes, HCPCS code G0323 *Care management services for behavioral health conditions, at least 20 minutes of clinical psychologist or clinical social worker time, per calendar month. (these services include the following required elements: initial assessment or follow-up monitoring, including the use of applicable validated rating scales; behavioral health care planning in relation to behavioral/psychiatric health problems, including revision for patients who are not progressing or whose status changes; facilitating and coordinating treatment such as psychotherapy, coordination with and/or referral to physicians and practitioners who are authorized by Medicare to prescribe medications and furnish E/M services, counseling and/or psychiatric consultation; and continuity of care with a designated member of the care team)* is time-based, and may be furnished in 20 minute increments. Medical record documentation would need to support the level of service provided. The MPFS Final Rule did not stipulate that start/stop times needed to be included, and you may follow your established policies and procedures for documentation of time-based codes.[11]

14. **Question:** Can HCPCS code G0323 be reported by the facility for an employed LSW if the patient is also enrolled in a Partial Hospitalization Program (PHP) or Intensive Outpatient Program (IOP)?

    **Answer:** The MPFS Final Rule did not address your specific scenario. The intent of the code is to provide behavioral health integration services that enhance the usual primary care by adding a level of support in the primary care setting. It is possible that there are patients that are in a PHP or IOP setting that may have the behavioral health integration services. You may wish to reach out to your local Medicare Administrative Contractor (MAC) for information specific to your situation.[12]

15. **Question:** Can psychologists and CSWs now bill Medicare for psychiatric diagnostic interview examinations with medical services or medical evaluation and management (E/M)?

    **Answer:** No, psychologists and CSWs may report CPT® 90791 *Psychiatric diagnostic evaluation* but are not designated as a type of provider that can provide medical services.[13]

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[10] Federal Register, Vol. 87, No. 222, November 18, 2022, page 69545, available at: https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

[11] Federal Register, Vol. 87, No. 222, November 18, 2022, page 69548, available at: https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

[12] Federal Register, Vol. 87, No. 222, November 18, 2022, page 69548, available at: https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

[13] Federal Register, Vol. 87, No. 222, November 18, 2022, page 69550, available at: https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

16. **Question:** For the Chronic Pain Management (CPM) services, is there a facility component that may be reported if performed in a hospital outpatient department (HOPD)?

    **Answer:** HCPCS codes G3002 *Chronic pain management and treatment, monthly bundle including, diagnosis; assessment and monitoring; administration of a validated pain rating scale or tool; the development, implementation, revision, and/or maintenance of a person-centered care plan that includes strengths, goals, clinical needs, and desired outcomes; overall treatment management; facilitation and coordination of any necessary behavioral health treatment; medication management; pain and health literacy counseling; any necessary chronic pain related crisis care; and ongoing communication and care coordination between relevant practitioners furnishing care, e.g. physical therapy and occupational therapy, complementary and integrative approaches, and community-based care, as appropriate. required initial face-to-face visit at least 30 minutes provided by a physician or other qualified health professional; first 30 minutes personally provided by physician or other qualified health care professional, per calendar month. (when using G3002, 30 minutes must be met or exceeded.)* and 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.)* are assigned to status indicator M *Items and Services Not Billable to the MAC*. At this time, there is no separate facility reimbursement for the services. CMS is monitoring these codes and may expand to include additional services in this area, particularly if auxiliary staff spends time performing services that should be included.[14]

17. **Question:** On modifier JZ *Zero drug amount discarded/not administered to any patient*, would this only be necessary for drugs assigned to status indicator G *Pass-Through Drugs and BiologicalsPass-Through Drugs and Biologicals* or K *Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals* for hospitals? How do we determine what is a single dose product?

    **Answer:** Hospital outpatient departments will be required to report the JZ modifier for all drugs from single-use vials or single-use packages that are separately payable under Medicare Part B as of July 1, 2023. Separately payable drugs are assigned to either status indicator G *Pass-Through Drugs and Biologicals* or status indicator K *Nonpass-Through Drugs and Nonimplantable Biologicals, Including Therapeutic Radiopharmaceuticals* under the Outpatient Prospective Payment System (OPPS) and therefore will be the only drugs that require use of either the JW or JZ modifier on or after July 1, 2023.[15]

    To identify single-dose products, you may wish to work with your pharmacy to identify these drugs.

18. **Question:** Are the JG and TB modifiers still required for 340B hospitals, or just the JG?

    **Answer:** Modifiers JG and TB should still be reported for informational purposes in 2023, although the usage of modifier JG will no longer trigger a reduction in the payment rate. Both modifiers have revised descriptions, effective January 1, 2023. The new descriptions are:

[14] Federal Register, Vol. 87, No. 222, November 18, 2022, page 69735, available at: https://www.govinfo.gov/content/pkg/FR-2022-11-18/pdf/2022-23873.pdf

[15] Federal Register, Vol. 85, No. 89, May 8, 2020, page 27557, https://www.govinfo.gov/content/pkg/FR-2020-05-08/pdf/2020-09608.pdf

JG *Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes*
TB *Drug or biological acquired with 340b drug pricing program discount, reported for informational purposes for select entities*[16]

You may wish to review the recording of our webinar on the 2023 Outpatient Prospective Payment System (OPPS) Final Rule webinar, 'What's Next for OPPS: A Look at the 2023 Final Rule' and is available under the Resources tab on the Vitalware by Healthcatalyst website.

[16] Federal Register, Vol. 87, No. 225, November 23, 2022, page 71974, https://www.govinfo.gov/content/pkg/FR-2022-11-23/pdf/2022-23918.pdf