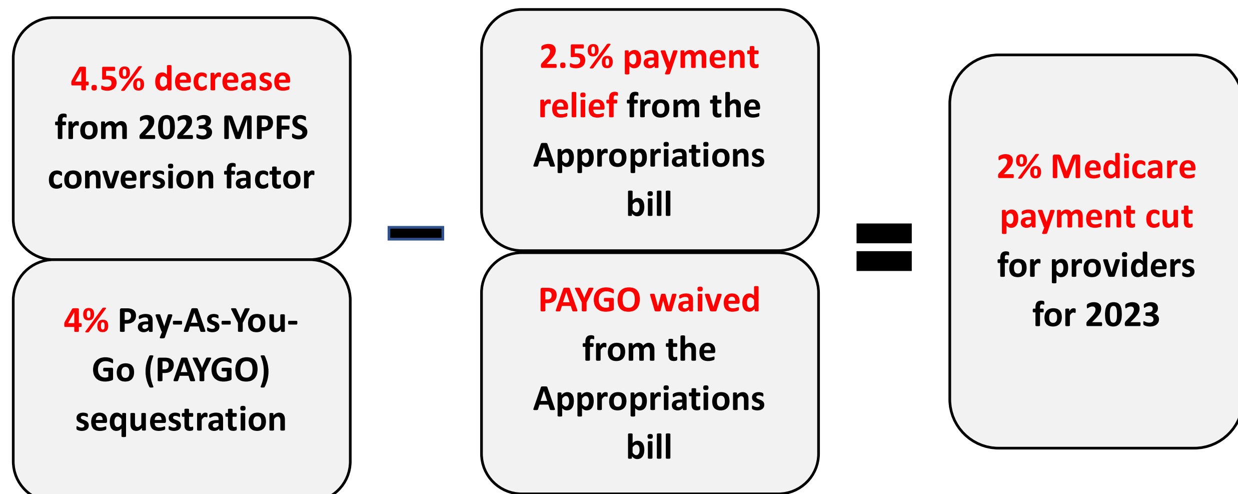
2023 Medicare Physician Fee Schedule:
Key Changes for Home Care Medicine

Overview

On November 7, the Centers for Medicare and Medicaid Services (CMS) released the Calendar Year (CY) 2023 Medicare Physician Fee Schedule (MPFS) and Quality Payment Program (QPP) Final Rule. This Final Rule includes updates and policy changes for Medicare payments under the MPFS, and other Medicare Part B issues, effective on or after January 1, 2023. We outline in this document key changes from the Final Rule as well as the Consolidated Appropriations Act of 2023 that you and your practice should be aware of in 2023, including projected payment cuts, deletion of relevant evaluation and management (E/M) codes, documentation changes, telehealth, and more. If you have any questions, please reach out to jchen@healthsperien.com.

Projected Payment Cuts

Providers will face a 2% payment cut beginning January 1, 2023. There was an estimated 8.5% Medicare payment cut for providers in 2023 due to the reduced conversion factor in the MPFS (4.5% cut) and Pay-As-You-Go (PAYGO) sequestration[1] (4% cut), a budgetary enforcement mechanism triggered by the American Rescue Plan. However, the Consolidated Appropriatons Act of 2023, signed into law on December 29, 2022, provided a 2.5% payment relief for the reduced MPFS conversion factor and waived the 4% PAYGO sequestration until 2025.



[1] The Statutory Pay-As-You-Go Act of 2010 (Statutory PAYGO) requires that mandatory spending and revenue legislation not increase the federal budget deficit over a 5- or 10-year period. Should such legislation be enacted without offsets, the Office of Management and Budget is required to implement sequestration, or across-the-board reductions, in certain types of mandatory federal spending. Medicare benefit payments and Medicare program integrity spending would be cut, but the reduction cannot be more than 4%.

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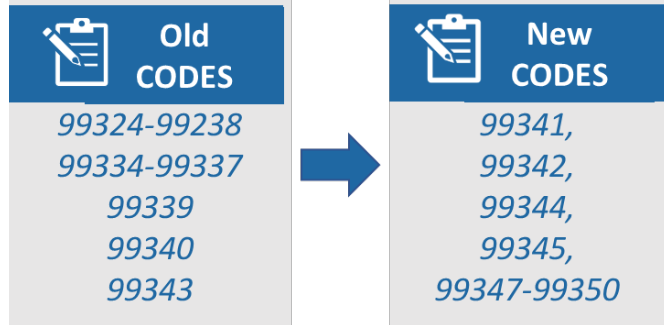
Deletion of Domiciliary, Rest Home, or Custodial Care Services Codes

Effective January 1, 2023, Domiciliary, Rest Home or Custodial Care Services E/M codes *99324-99238, 99334-99337, 99339, 99340* will be deleted. Home or Residence Services E/M code *99343* will also be deleted. Providers can instead use Home or Residence Services E/M codes *99341, 99342, 99344, 99345, 99347-99350* to bill for home visits, which include services provided in assisted living facilities, group homes, custodial care facilities, and residential substance abuse treatment facilities, as well as a patient's home.



The American Medical Association (AMA) CPT® Editorial Panel noted they deleted the family of domiciliary codes with the aim of simplifying code selection criteria and making them more clinically relevant and intuitive.

Home Visit Documentation Changes

Effective January 1, 2023, the AMA CPT® Editorial Panel has redefined the Other E/M visits (i.e., inpatient and observation visits, emergency department visits, nursing facility visits, home visits, and cognitive impairment assessment) so that they parallel the office/outpatient (O/O) E/M visits, where visit level will be selected based on the amount of practitioner time spent with the patient or the level of medical decision-making (MDM) as redefined in the CPT® E/M Guidelines.

In 2021, the AMA CPT® Editorial Panel revised the O/O E/M visit code family. Effective January 1, 2021, the CPT Editorial Panel redefined the O/O E/M visits, such that visit level is selected based on the amount of practitioner time spent performing the visit or the level of MDM as redefined in the CPT E/M Guidelines.

Telehealth

The Consolidated Appropriatons Act of 2023 extended telehealth flexibilities for Medicare beneficiaries through December 31, 2024, including:

- Extension of the waiver for the originating site requirement, enabling beneficiaries to receive telehealth services at home
- Expansion of practitioners eligible to furnish telehealth services
- Extension of flexibilities that allow federally qualified health centers and rural health clinics to serve as originating or distant sites for the delivery of telehealth services
- Delay of the in-person requirement for mental health services furnished through telehealth
- Continued coverage of audio-only telehealth services

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Reduction to Home Visit RVUs

Please find below the updated RVUs for home visit CPT® codes in CY 2023.

Code	2022 RVU	2023 RVU
99341	1.01	1.00
99342	1.52	1.65
99344	3.38	2.87
99345	4.09	3.88
99347	1.00	0.90
99348	1.56	1.50
99349	2.33	2.44
99350	3.28	3.60

The RVUs were updated as a result of regular code revaluations based on recommendations from a committee involving the AMA and national medical specialty societies. In 2021, the AMA RVS Update Committee (RUC) released a survey to providers to rework home visit relative value units (RVUs).[2] Results from that survey informed the revaluation of home visit codes that have been finalized in the MPFS.

Considerations for 2023

Accurate medical billing and coding is key to ensuring proper reimbursement. In addition, accurate and complete documentation is critical as you and your practice bill the appropriate CPT® and HCPCS codes to fully capture the scope of services you provide to patients. Many services that home care medicine providers deliver to patients include:

Chronic Care Management (CCM): CCM services are generally non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patients.

- **99490** - Non-complex CCM is a **20-minute timed service** provided by clinical staff to coordinate care across providers and support patient accountability.

[2] Each CPT® code has RVUs assigned to it which, when multiplied by the conversion factor and a geographical adjustment, creates the compensation level for a particular service.

- **99439** - **Each additional 20 minutes** of clinical staff time spent providing non-complex CCM directed by a physician or other qualified health care professional (billed in conjunction with CPT code99490)
- **99487** - Complex CCM is a **60-minute timed service** provided by clinical staff to substantially revise or establish comprehensive care plan that involves moderate- to high-complexity medical decision making.
- **99489** - Each **additional 30 minutes** of clinical staff time spent providing complex CCM directed by a physician or other qualified health care professional (report in conjunction with 99487; cannot be billed with 99490)
- **99491** - CCM services provided personally by a physician or other qualified health care professional for at least 30 minutes.

Advance Care Planning (ACP): ACP is the face-to-face time a physician or other qualified health care professional spends with a patient, family member, or surrogate to explain and discuss advance directives.

- **99497** - **First 30 minutes** (minimum of 16 minutes)
- **99498** - Add-on for **additional 30 minutes**

Care Plan Oversight (CPO): CPO is a physician's supervision[3] of patients under the care of home health agencies or hospices who require complex or multidisciplinary care modalities.

- **G0181** - Physician supervision of a patient receiving Medicare-covered services provided by a participating home health agency (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care, integration of new information into the medical treatment plan and/or adjustment of medical therapy, within a calendar month, 30 minutes or more.
- **G0182** - Physician supervision of a patient under a Medicare-approved hospice (patient not present) requiring complex and multidisciplinary care modalities involving regular physician development and/or revision of care plans, review of subsequent reports of patient status, review of laboratory and other studies, communication (including telephone calls) with other health care professionals involved in the patient's care.

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[3] Nurse practitioners, physician assistants, and clinical nurse specialists practicing within the scope of state law may bill for CPO. These advanced practice practitioners (APPs) must have been providing ongoing care for the beneficiary through evaluation and management services. APPs may not bill for CPO if they have been involved only with the delivery of the Medicare-covered home health or hospice service.

Transitional Care Management (TCM): TCM addresses the hand-off period between the inpatient and community setting. After a hospitalization or other inpatient facility stay (e.g., in a skilled nursing facility), the patient may be dealing with a medical crisis, new diagnosis, or change in medication therapy. Providers often manage their patients' transitional care.

- **99495** - **Moderate medical complexity** requiring a face-to-face visit within 14 days of discharge
- **99496** - **High medical complexity** requiring a face-to-face visit within seven days of discharge

Non Face-to-Face Prolonged Service: This is used to report the ***total duration of non-face-to-face time*** spent by a provider on a given date providing prolonged service, even if the time spent by the provider on that date is not continuous.

- **99358** - Prolonged service before and/or after direct patient care, **first hour**
- **99359 - Each additional 30 minutes** (list separately in addition to code for prolonged service)

Home Health Certifications and Recertifications: These codes are used for the certification and recertification of Medicare-covered home health services.

- **G0179** - Recertification of a patient for home health care
- **G0180** - Certification of a patient for home health care