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New Model for MIPS is coming, while Advanced APMs get a tough break.

- 99282 (Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and straightforward medical decision making).
- 99283 (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).
- 99284 (Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making).
- 99285 (Emergency department visit for the evaluation and management of a patient, which requires a medically appropriate history and/or examination and high level of medical decision making).

Retaining same-day critical care, referral policies

CPT guidelines allow same-day critical care (**99291-99292**) and ED visits "when after completion of the emergency department service, the condition of the patient changes and critical care services are provided."

CMS finalized a similar policy when it revised its critical care guidelines. The ED visit must come first and be performed before the patient needed critical care services. But CMS provides more detail in its policy. For example, the documentation must show which service came first, and that the critical care service is separate and distinct.

CMS also intends to keep the policy in IOM 100-04, chapter 12, second 30.6.11(E), which details how an ED physician and a second, non-ED physician report services for the same person on the same day, but will expand the policy to "to clarify that these policies apply to [initial] observation care," according to the proposed rule.

One scenario in the proposed rule describes a situation where a physician tells the patient to go to the emergency room, and the ED physician asks the patient's physician to come to the hospital to evaluate the patient in the hospital and advise the ED physician as to whether the patient should be admitted as an inpatient, placed in observation status or sent home.

If the patient's personal physician goes to the emergency room and puts the patient in observation, the patient's personal physician should bill an initial hospital visit. The ED physician should bill the appropriate ED visit, according to the proposed rule.

4 codes will keep their work RVUs

CMS did not propose revised work relative value units (wRVU) for ED codes 99282-99285, even though the AMA's RVS Update Committee (RUC) suggested a reduction for 99284. However, CMS and the RUC both agreed to cut the wRVUs for 99281 from 0.48 to 0.25. — *Julia Kyles, CPC (jkyles@decisionhealth.com).* ■

Quality Payment Program

New model for MIPS is coming, while Advanced APMs get a tough break

For CY 2023 changes to the Quality Payment Program (QPP) and Merit-based Incentive Payment System (MIPS), CMS focuses its attention on the MIPS Value Pathways (MVP), a new measures regimen that begins on a voluntary basis in 2023. A mandatory adoption deadline remains fluid.

CMS is serious about promoting the MVP program, proposing to open its measures to public comments and hold an "annual public facing webinar" on the subject.

The agency announced five new MVPs in the proposed rule:

- Advancing Cancer Care.
- Optimal Care for Kidney Health.
- Optimal Care for Neurological Conditions.
- Supportive Care for Cognitive-Based Neurological Conditions.
- Promoting Wellness.

The previously announced MVPs include Advancing Care for Heart Disease; Optimizing Chronic Disease Management; Advancing Rheumatology Patient Care; Adopting Best Practices and Promoting Patient Safety within Emergency Medicine; Improving Care for Lower Extremity Joint Repair; Patient Safety and Support of Positive Experiences with Anesthesia; and Coordinating Stroke Care to Promote Prevention and Cultivate Positive Outcomes.

Owing to the high level of condition and specialty specificity of the MVPs, CMS proposes to established MVP "subgroups" under which groups with diverse

specialties or patient populations can register. In 2023, such groups can register as subgroups or as regular MVP reporters, but CMS says subgroups will be mandatory for eligible providers in multispecialty groups who choose to participate in MVP starting in 2026.

Each group with a taxpayer identification number (TIN) would be able to create multiple subgroups, but eligible providers with their own TIN and national provider identifier (NPI) would be limited to one subgroup. Subgroups would be scored on their affiliated group's population health measure and cost measure scores, if appropriate, as well as on their MVP performance.

"This issue of how to determine the specialty of a provider remains open to discussion, as we recognize that the registered specialty in PECOS is often incorrect," says Lauren Patrick, president and CEO of qualified registry Healthmonix in Malvern, Pa. "CMS has now proposed reviewing claims to determine specialties as we move forward."

Get on board

Experts agree that, notwithstanding the lack of a definite target date for mandatory adoption, the MVP program is likely to stick.

"Early MVP adopters will have an advantage over the later entrants," says David Halpert, chief, client team at Roji Health Intelligence in Chicago. "As we saw with ACOs, those who started sooner and gained experience outperformed those who waited to make the jump. MVP participants need advanced technology to link their quality reporting to population-based interventions in order to excel in the Cost and Foundational level measures. The early adopters will be developing and deploying their improvement strategies, while the second wave struggles to keep up."

Patrick expects the big challenge for participants will be "the technology and administration required to submit. It is unclear as to how many EHRs and registries will be ready to report MVPs in 2023, as it is a new reporting mechanism."

APM entities that report MIPS will have the option to report Promoting Interoperability under MIPS as a MIPS entity rather than at the eligible clinician (EC) level starting in 2023, CMS proposes.

Tough 'gap' year for AAPMs

The proposed rule contains bad news for Advanced APM (AAPM) participants in QPP: The big come-on for that program, the 5% lump sum of a qualifying provider's (QP) estimated aggregate payment amount for covered professional services, is going away in 2023. Worse still, while CMS plans to replace that with a "an increased physician fee schedule update based on the QP conversion factor" for QPs of 0.75% starting with performance year 2024, they appear headed to get nothing at all for 2023 except what the terms of their APM agreement calls for.

This is based on the terms of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the law that instituted QPP, and CMS believes it can only be overridden by Congress, not by regulation; thus, the rule says, under the PFS in payment year 2025, QPs will be "paid at the same rate as any other eligible clinicians who are not subject to MIPS [for 2023]," leading to "a lack of any available financial incentive under the Quality Payment Program for QPs" that year.

The agency will issue an RFI asking for help. Observers think it might come up in a congressional bill.

"I do know there's an active push to get it included in an end-of-year physician spending package and it's supported by some pretty influential groups [like the AMA]," says Suzanne Joy, senior public affairs advisor for Holland & Knight LLP in Washington, D.C. "Because it's a one-year gap, I think that there's a pretty reasonable chance Congress might act to at least extend [the lump sum] one year."

Another issue for AAPMs: Proposed changes in the QP thresholds that have to be met to qualify as an AAPM. CMS proposes an increase from 50% to 75% for the payment threshold and 35% to 50% percent for the patient count threshold. "This will knock a lot of APM entities out of contention, but CMS says they're bound by statute," Joy says, "so add this to the list of things Congress will need to address by the end of year along with the 5% [Advanced] APM bonus."

MIPS scoring remains steady

The regular MIPS scoring method is largely unchanged: Scoring weights for 2023 are 30% for the Quality performance category; 30% for the Cost performance category; 15% for the Improvement Activities performance category; and 25% for the Promoting Interoperability performance category. The performance

threshold for MIPS remains at 75 points, based on the 2019 MIPS payment year rather than 2021, in part because of COVID disruptions that caused some quality scores to be reweighted.

The data completeness threshold stays at 70% in 2023 but will be increased to 75% in 2024 and 2025. Measures are slightly amended as usual, including the addition of a "health equity" quality measure. — *Roy Edroso* (*redroso@decisionhealth.com*) ■

Physician fee schedule

Fee schedule round-up: Coding, billing, policy and regulatory changes

Don't miss out on additional policy changes contained in the proposed 2023 Medicare physician fee schedule, from supply cost revisions to enrollment updates. Get all the latest here:

- **Potentially misvalued codes.** CMS is asking for comment on whether to value a long list of cataract and retinal procedure codes in a non-facility (office) setting and whether it is safe for the procedures to be performed there after a nominator requested the agency to increase payment for them in the physician office setting. Codes singled out for revaluation include: Goniotomy (**65820**), transluminal dilation of aqueous outflow canal (**66174**), cataract codes **66982**, **66984**, **66989** and **66991**, as well as retinal procedures, **67015**, **67036**, **67039**-**67043**, **67108** and **67113**.

Another nominator requested revaluation of **20931**, an add-on code for structural allograft for spine surgery, stating that the code was undervalued. CMS was tepid on whether the nominator "has provided sufficient evidence to demonstrate" whether the code was misvalued but requests comment, independent analysis and studies in support or disagreement with the nomination. The agency rejected another nomination to revalue physician home visit codes (**99344**-**99345** and **99349**-**99350**), in part because the codes have already gone through the revaluation process as part of their revision under the AMA's 2023 update of the E/M guidelines.

- **Figuring out how to value postop visits.** CMS is looking to restart the conversation about valuation of the estimated 4,000 surgical codes with 0-, 10- and 90-day global periods. The agency is seeking public comment on what services are currently performed during the global period and how technology and other issues such as the PHE may have had an impact. "We continue to believe that: (1) there is strong evidence suggesting that the current RVUs for global packages are inaccurate; (2) many interested parties agree that the current values for global packages should be reconsidered, whether they believe the values are too low or too high; and (3) it is necessary to take action to improve the valuation of the services currently valued and paid under the PFS as global surgical packages," the agency states.

According to analysis conducted by RAND, "the reported number of E/M visits matched the expected E/M visits for only 4 percent of reviewed 10-day global packages and 38 percent of reviewed 90-day global packages," CMS states in the proposed rule.

- **Four new remote therapeutic monitoring (RTM) G-codes could allow more flexible billing.** CMS is worried that the code descriptions of RTM treatment management codes **98980** and **98981** don't quite match up with Medicare policies because the codes allow non-physician practitioners (NPP), such as physical and occupational therapists, to oversee clinical staff performing the work of the codes. Quoting the RVS Update Committee (RUC), CMS states that the work includes: "Communicating with the patient throughout the month, resolving technology or data transmission concerns, reviewing data with the billing practitioner, updating and modifying care plans, and addressing lack of patient improvement."

CMS asserts that "these activities performed by clinical staff of the billing practitioner would be considered services provided incident to the services of the billing practitioner." But therapists are not allowed to bill for incident-to services under federal Medicare law, the agency states. CMS allowed therapists to be paid for codes 98980 and 98981 anyway in this year's fee schedule, but for 2023, the agency is proposing to create two new G codes that would permit therapists to bill for the services.

In addition, the agency wants to create two additional G codes that would allow physicians to provide RTM treatment management services on an incident-to basis, but under general supervision, not the direct supervision required by Medicare's existing incident-to policy. Direct supervision requires the supervising practitioner to be present in the physician offices while the service is provided; general supervision does not require the physician to be physically present, but only to provide overall direction of the service. Allowing RTM treatment management to be