BRACH EICHLER LLC

NEW JERSEY STATE SOCIETY OF ANESTHESIOLOGISTS

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LEGAL REPORT

PRESENTED BY

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I. COVID-19 LEGAL UPDATES

Brach Eichler has strived to keep abreast numerous legal developments that occurred during the nationwide novel coronavirus (COVID-19) public health emergency. Brach Eichler has created a COVID-19 Resource Center that consolidates our various important client alerts and webinar series information in one place. Please visit the Resource Center for updates at https://www.bracheichler.com/covid-19-resource-center/.

II. NEW JERSEY LEGAL DEVELOPMENTS

A. New Jersey Law Protects Health Care Workers During Change of Ownership

On August 18, 2022, Governor Murphy signed into law Senate Bill 315, which establishes employment protections for eligible employees during a change in control of their health care entity employer. The law will be effective November 16, 2022.

Under the new law, non-governmental health care entities must offer continued employment to all eligible employees for at least four months following the transfer of control, without any reduction in wages, paid time off, or the total value of their benefits – including health care, retirement, and education benefits. Eligible employees include any individuals employed within a 90-day period immediately preceding the change in control, with the exception of managerial employees and any person discharged for cause by the during that 90-day period.

During the four-month transitional period, all available employment positions must be offered in writing to eligible employees who previously held those positions, and the offers must remain open for at least ten business days. In the event that the number of available employment positions are less than the total number of eligible employees, then employment will be based on seniority and experience. An employee who is retained pursuant to the new law cannot be terminated without cause during the transitional period, unless the termination is a result of downsizing, in which case priority must be given to senior and experienced employees. Further, laid off employees must be offered any positions they held, if they are subsequently restored during

the transitional period. After the transitional period, the successor employer must evaluate all retained employees and offer to continue to retain them if their performance during the transitional period was satisfactory.

Health care entities subject to the new law include general and special hospitals, ambulatory surgical centers, ambulatory care facilities, licensed imaging centers, mental hospitals, public health centers, diagnostic centers, treatment centers, rehabilitation centers, extended care facilities, skilled nursing homes, nursing homes, intermediate care facilities, outpatient clinics, dispensaries, home health care agencies, and residential health care facilities.

B. Amendments to Out of Network Arbitration Process Becomes Law

On July 29, 2022, Governor Phil Murphy signed into law Bill S1177 to amend certain aspects of the "Out-of-network Consumer Protection, Transparency, Cost Containment and Accountability Act" (the Act) relating to the arbitration process for claims involving health insurance carriers who are subject to the Act. Specifically, the amendments extend the amount of time that an insurance carrier and healthcare provider have to negotiate a settlement in the event of an inadvertent use of out-of-network services from 30 to 60 days, and extends the deadline for the carrier, provider, or covered person to initiate binding arbitration in the event of a failure to reach a settlement from within 30 days of the final offer to within 60 days of the final offer. The amendments also require an arbitrator to include detailed written findings with each arbitration decision. The detailed written findings are to be an analysis of the decision, including information concerning any databases, previous awards, or other documentation or arguments that contributed to the arbitrator's decision.

C. DCA Better Aligns COVID-19 Protocols for Office Practices with Current Guidance

On July 22, 2022, the New Jersey Division of Consumer Affairs (DCA) issued Administrative Order No. 2022-01 (AO 2022-01) setting forth modified requirements for health care professionals working in settings not requiring licensure by the New Jersey Department of Health (NJDOH), to practice in a manner that is consistent with current guidance issued by the Centers for Disease Control and Prevention (CDC), NJDOH, the federal Occupational Safety and Health Administration (OSHA), and the health care professionals' respective local health department. AO 2022-01 explicitly modifies Administrative Order No. 2021-11 (AO 2021-11).

AO 2021-11 (superseding DCA Administrative Order No. 2020-07) was entered on May 6, 2021, when the Public Health Emergency and State of Emergency, initially declared on March 9, 2020 pursuant to Executive Order 103, were both still in effect. When AO 2021-11 was entered, it included enforceable provisions for the delivery of health care in office-based settings not licensed by NJDOH, which were consistent with the then-current guidance from the CDC, NJDOH, and OSHA. AO 2021-11 mandated, among other things, that health care professionals utilize telemedicine to the greatest extent possible; screen and check temperatures of patient, companions, and staff before permitting entry into the office; require patients, companions, and staff to wear face coverings or face masks; facilitate social distancing to minimize person to person contact; adopt enhanced protocols for office cleaning and disinfection; and establish rigorous protections for staff.

While AO 2021-11 remains effective, DCA recognizes that some of the provisions within AO 2021-11 are no longer consistent with now-current and potential future CDC, NJDOH, OSHA, and local health department guidance and standards, and, as such, it is necessary to modify COVID-19 related mandates for health care professionals in office settings. In response, DCA has removed many of the specific, static requirements within AO 2021-11 and has chosen instead to mandate full compliance with all now-current (and future) guidance from CDC, NJDOH, OSHA, and local health departments.

The modified standards require that all health care professionals practicing in office[1] settings do the following:

1. Provide in-person adult and pediatric services in an office and practice consistent with their scope of practice as well as applicable statutes and regulations except where conditions of practice have been and remain waived in connection with the State of Emergency;
2. Practice in a manner consistent with all applicable COVID-19 related guidance from the CDC, NJDOH, OSHA, and local health department guidance;
3. Stay informed about applicable CDC, NJDOH, OSHA, and local health department guidance;
4. Monitor the community spread of COVID-19 via the NJDOH's Statewide Weekly COVID-19 Variant Surveillance Reports and the CDC Community Levels and adjust office practices in a manner consistent with CDC and NJDOH recommendations based on the level of community spread;
5. Protect staff from retaliation for engaging in conduct recommended by CDC, NJDOH, OSHA and their respective local health department; and
6. Ensure that health care practices in registered surgical practices required to be licensed as ambulatory surgery centers (ASCs) by NJDOH, but not yet licensed, perform in a manner consistent with all NJDOH[2] imposed requirements for ASCs.

DCA effectively adopted CDC, NJDOH, OSHA, and local health department guidance as its own. As a result, health care practitioners practicing in *office* settings (as defined in the above footnote) are subject to the following as of the date of publication of this report:

Screening Patients and Staff

1. Identify everyone, including patients, non-Heath Care Personnel (non-HCP), and Health Care Personnel (HCP), entering the facility, regardless of their vaccination status, who have had any of the following, so that they can

[1] For purposes of AO 2022-01 and AO 2021-11, "office" means a health care practice setting not licensed by the NJDOH, including, but not limited to, health care professional offices, private practices, clinics, urgent care centers, and community medical centers.

[2] Executive Directive 20-016 (Revised) COVID-19 Protocols for Ambulatory Surgery Centers Resuming Elective Surgery and Invasive Diagnostic Procedures Pursuant to Executive Order No. 145

be properly managed: (1) a positive viral test for SARS-CoV-2; (2) symptoms of COVID-19; or (3) close contact with someone with COVID-19 infection (for patients and visitors).

2. Rely upon NJDOH COVID-19 Weekly Surveillance Report to inform decision-making based on the CDC's community transmission rates, which range from low to high, in the county in which the practice is located.

- Low to Moderate – actively evaluate patients for fever and other signs of COVID-19 or acute respiratory infection at least daily.
- Substantial to High – consider increasing the frequency of evaluation of patients for fever and other signs of COVID-19 or acute respiratory infection.

Masking

1. Low to Moderate Community Transmission Rates – Under some circumstances patients and non-HCP may forgo masking, but HCP are required to wear masks when they are in areas where patient encounters occur.
2. Substantial to High Community Transmission Rates - Masking is required for patients, non-HCP and HCP in all health care settings.

Protections for Staff

1. The Division on Civil Rights provides that an employer cannot discriminate against staff because of actual or perceived race, national origin, religion, disability, or other Law Against Discrimination (LAD) - protected characteristic. The LAD also prohibits bias-based harassment that creates a hostile work environment. These protections apply even if the conduct at issue stems from concerns related to COVID-19. LAD's Protections Related to COVID-19 in Employment.

D. New Law Protects Nondisclosure of Patient Information Relating to Reproductive Healthcare Services

Effective July 1, 2022, Governor Phil Murphy signed into law Bill A3975 to protect the disclosure of patient information relating to reproductive health care services, and to protect access to health care, medical services, and procedures related to an abortion for persons who come to New Jersey from jurisdictions in which these actions are illegal. "Reproductive health care services" is defined as all medical, surgical, counseling, or referral services relating to the human reproductive system, including services relating to pregnancy, contraception, or termination of a pregnancy. The new law generally provides that in any civil action, a medical provider is barred from disclosing the following communications or information, unless the patient explicitly consents in writing to the disclosure: (i) any communication made to the medical provider, or any information obtained by the medical provider from a patient relating to reproductive health care services; or (ii) any information obtained by personal examination of a patient relating to reproductive health care services that are permitted under New Jersey law.

E. New Law Prohibits Extradition of Individuals Seeking Reproductive Health Care Services in New Jersey

Effective July 1, 2022, Governor Phil Murphy signed into law Bill A3974 to prohibit individuals from being extradited to another state if the person is accused of providing, receiving, assisting in providing or receiving, providing material support for, or traveling to obtain reproductive health care services that are permitted under New jersey law. "Reproductive health services" is defined as all medical, surgical, counseling, or referral services relating to the human reproductive system, including, but not limited to, services relating to pregnancy, contraception, or termination of a pregnancy.

F. Nearly All New Jersey Hospitals Face Medicare Penalties for Non-Par Readmission Rates

Most hospitals in New Jersey (60 out of 64) will once again pay a penalty for failing to prevent Medicare beneficiaries' hospital readmissions within 30 days of discharge. Listed below is a chart showing the ten most severely penalized hospitals in New Jersey in FY 2022 along with prior FY 2021 data.

Name of the Hospital	Penalty deducted for each payment FY 2021	Penalty deducted for each payment FY 2022
St. Joseph's Hospital and Medical Center (Paterson, NJ)	2.32%	2.46%
Virtua West Jersey Hospitals (Voorhees, NJ)	1.44%	2.35%
Hunterdon Medical Center (Flemington, NJ)	2.49%	2.29%
Hackensack Meridian Health (Westwood, NJ)	3.00%	2.01%
Holy Name Medical Center (Teaneck, NJ)	1.23%	1.98%
University Medical Center of Princeton (Plainsboro, NJ)	1.54%	1.98%
Inspira Medical Center (Elmer, NJ)	2.35%	1.97%
East Orange General Hospital (East Orange, NJ)	1.39%	1.64%
Saint Clare's Hospital (Denville, NJ)	1.52%	1.53%
Englewood Hospital and Medical Center (Englewood, NJ)	2.13%	1.41%
Inspira Medical Center (Vineyard, NJ)	1.56%	1.41%

By way of background, in 2012, as part of the Affordable Care Act, the Centers for Medicare and Medicaid Services (CMS) implemented the Hospital Readmissions Reduction Program (HRRP) to reduce excess readmissions. Under the HRRP, CMS penalizes hospitals with readmission rates above national averages for Medicare patients originally hospitalized for one of six conditions: heart attack, heart failure, coronary artery bypass graft surgery, pneumonia, chronic obstructive pulmonary disease, and hip or knee replacements.

For FY 2022, which runs from October 1, 2021 to September 30, 2022, using patient data from July 1, 2017 through December 1, 2019, CMS determined that it will cut payments to the underperforming hospitals by as much as 3% for each Medicare case.

III. FEDERAL LEGAL DEVELOPMENTS

A. OIG Issues Special Fraud Alert Regarding Telemedicine Arrangements

On July 20, 2022, the U.S. Department of Health and Human Services Office of Inspector General (OIG) released a special fraud alert (the Alert) highlighting the growth and prevalence of fraudulent and suspect arrangements within telemedicine and telehealth. The OIG stated that telehealth, telemedicine, and telemarketing services have carried out fraudulent schemes by aggressively recruiting physicians and non-physician practitioners (collectively, Providers) and paying kickbacks to Providers in exchange for the ordering of unnecessary items or services, including durable medical equipment (DME), genetic testing, wound care items, and other prescription items.

The following is a non-exhaustive list of seven "suspect characteristics" identified in the Alert that suggest a heightened risk of fraud and abuse:

1. Patients are identified and recruited through call centers, health fairs, recruiters, telemarketing channels, or social media by advertising free or low out-of-pocket cost items or services.

2. Lack of sufficient contact with or information from patient to assess the medical necessity of prescribed items or services.

3. Compensation based on volumes of items or services ordered or prescribed.

4. Refusal to accept insurance from payors not affiliated with federal healthcare programs.

5. Misrepresentation on whether the company actually bills federal healthcare programs.

6. Predetermining or limiting the types of products or services that clinicians can prescribe, such as restricting prescriptions to only certain DME or prescription creams.

7. Not expecting, enabling, or requiring clinicians to follow up with patients.

While telemedicine remains a useful, viable and encouraged modality for treatment, Providers must remain wary of fraudulent arrangements. In anticipation of enforcement and whistleblower activity that will attempt to leverage the Alert, Providers may consider reassessing the compliance of their operations with respect to furnishing services or ordering products, tests, and prescription drugs for telemedicine patients.

B. 36 Individuals Charged with $1.2B in Alleged Health Care Fraud

On July 20, 2022, the Department of Justice (DOJ) announced that three dozen individuals were indicted for acts of allegedly accepting illegal monetary kickbacks, luring unsuspecting elderly individuals into criminal schemes and performing unnecessary medical tests for a

cumulative $1.2 billion in fraudulent schemes. The coordinated investigations primarily targeted the alleged payment of kickbacks and bribes by lab operators in exchange for the referral of patients by medical professionals working with allegedly fraudulent telemedicine and digital health companies.

Some of the defendants are said by the DOJ to operate a telemarketing network that lured elderly and disabled patients into a criminal scheme. Marketers allegedly had telemarketers use deceptive techniques to induce Medicare beneficiaries to agree to cardiovascular genetic testing, and other genetic testing and equipment. The charges allege that these companies arranged for medical professionals to order expensive genetic tests and medical equipment regardless of whether the patients needed them, and that they were ordered without any patient interaction or with just a brief phone call. One case charged involved the operator of several clinical laboratories, who was charged in connection with a scheme to pay over $16 million in kickbacks to marketers who paid kickbacks to telemedicine companies and call centers in exchange for doctor orders.

While telemedicine companies may engage practitioners to provide telemedicine services to patients in a compliant way, practitioners can only order or prescribe items and/or services for patients whom they have examined and must ensure that such items and services are medical necessary and clinically appropriate. Telemedicine companies must pay careful attention to how they compensate their practitioners for providing virtual healthcare services and ensure that the compensation model complies with the law and does not induce a practitioner to prescribe or order an item or service.

C. CMS Proposes 2.7% Increase to Hospital Outpatient and ASC Rates for 2023

On July 15, 2022, the Centers for Medicare and Medicaid Services (CMS) released its 2023 Hospital Outpatient Prospective Payment System (OPPS) and Ambulatory Surgical Center (ASC) Payment System Proposed Rule, which includes, among other things, updates to hospital outpatient payment rates. The Proposed Rule has a 60-day comment period (through September 13, 2022) and the final rule will be issued in early November 2022. Pursuant to the Proposed Rule, CMS is proposing to increase Hospital OPPS payment rates by 2.7% in 2023. The Proposed Rule also includes proposals aligned with several key goals of the Biden Administration, including advancing health equity in rural areas, promoting competition in the healthcare system, promoting behavioral health telemedicine remote services, and promoting safe, effective, and patient-centered care.

D. CMS Proposes 4.43% RVU Conversion Factor Cut for 2023

On July 7, 2022, the Centers for Medicare and Medicaid Services (CMS) issued a proposed rule for the 2023 Medicare Physician Fee Schedule (PFS). The proposed rule would decrease the PFS conversion factor by $1.53 to $33.08, a 4.43% drop in the current conversion factor of $34.61. The conversion factor is the dollar amount assigned to the Relative Value Unit (RVU) for each CPT code. A decrease in the conversion factor therefore translates in payment cuts for physicians at the reimbursement level and at the compensation level for physicians paid under an RVU-based methodology. CMS explained that the proposed reduction reflects the statutorily required update to the conversion factor for CY 2023 of 0%, the expiration of the 3% increase in PFS payments

for CY 2022 as required by the Protecting Medicare and American Farmers From Sequester Cuts Act, and statutorily required budget neutrality adjustments.

In addition to the 4.43% reduction to the conversion factor, CMS's regulatory impact analysis (RIA) estimates that anesthesiologist will see a 1% decrease in payments based on policy changes proposed for 2023. However, cumulative payment changes experienced by individual clinicians or practices will vary because actual payment depends on several factors, including locality-specific rates and the specific procedure codes billed. A detailed comparison of 2022 payment rates and proposed 2023 payment rates related to CPT codes prepared by the American Society of Anesthesiologists is set forth in **Exhibit A** hereto.

E. CMS Transparency in Coverage Rule Took Effect July 1, 2022

The Transparency in Coverage Final Rule (the TiC Final Rule), a Trump-era initiative issued by the Centers for Medicare and Medicaid Services (CMS) on October 29, 2020, officially took effect on July 1, 2022, following a six-month delay in implementation to allow payors to come into compliance. The purpose of the TiC Final Rule is to help consumers understand healthcare pricing and curtail the rise in healthcare spending by enabling a participant, beneficiary, or enrollee to shop for items and services. CMS touts the TiC Final Rule as "a historic step toward putting healthcare price information in the hands of consumers."

Effective July 1, 2022, the TiC Final Rule requires health plans to disclose online, in machine-readable files: (1) their negotiated rates with in-network providers; and (2) historical billed charges and allowed amounts paid to out-of-network providers. The machine-readable file requirements are applicable for plan years beginning on or after January 1, 2022. While the TiC Final Rule also intended that payors disclose negotiated rates for covered prescription drugs, the U.S. Department of Health and Human Services, Labor, and Treasury (the Departments) indefinitely deferred enforcement of the machine-readable file requirement for prescription drugs while they consider whether the requirement is appropriate.

Additional requirements will go into effect in 2023 and 2024. As part of a continued effort to assist individuals to effectively shop for items and services, beginning January 1, 2023, the TiC Final Rule requires that health plans to create a tool whereby their enrollees can receive real-time, personalized estimates of potential cost-sharing liability for 500 designated items and services. Beginning on January 1, 2024, the cost sharing tool must provide the same information for *all* covered items and services. Noncompliant payors could face fines of up to $100 per day for each violation and for each individual affected, with limited exceptions.

F. OIG Semiannual Reports to Congress Identifies Nearly $3 Billion in Expected Recoveries

On June 6, 2022, the Office of Inspector General (OIG) of the U.S. Department of Health and Human Services (HHS) released its Semiannual Report to Congress (the Report), which summarizes the agency's activities from October 1, 2021 through March 31, 2022 (the Reporting Period). Among other accomplishments, the Report highlights nearly $3 billion in expected recoveries as a result of audits and investigations. In its Report, OIG also explains its

continued focus on significant and high-risk issues in healthcare and its data analytics capabilities.

In the six-month Reporting Period, OIG reported 320 criminal enforcement actions against individuals or entities that engaged in crimes impacting HHS programs. In addition, OIG reported 320 civil actions, including false claims and unjust-enrichment lawsuits, civil monetary penalty settlements, and administrative recoveries relating to provider self-disclosures. Further, OIG excluded 1,043 individuals and entities from participation in federal healthcare programs.

OIG explained that it continues to focus on significant and high-risk issues in healthcare. Specifically, the Report details specific areas of concern, including responding to the COVID-19 pandemic and other emergencies, improving oversight of nursing homes, ensuring health and safety of vulnerable populations, preventing and treating opioid misuse, and ensuring program integrity for federal healthcare programs.

Further, OIG focused on its data analytics capabilities. The agency explained that it closely reviews data to identify concerning trends and outliers, issue compliance guidance for the healthcare industry, and make recommendations to HHS to improve program integrity. OIG noted that its data analyses focused on evolving and emergent areas, such as telehealth and cybersecurity.

Exhibit A

American Society of Anesthesiologists
[attached]

American Society of Anesthesiologists

NEWS

July 08, 2022

Anesthesiologists Face Additional Payment Cuts as CMS releases its 2023 Physician Fee Schedule and Quality Payment Program Proposed Rule

On July 7, 2022, the Centers for Medicare & Medicaid Services (CMS) has released its CY 2023 Medicare Physician Fee Schedule (PFS) proposed rule which includes proposals related to Medicare physician payment and the Quality Payment Program (QPP). Within the fee schedule, CMS proposed Medicare payment cuts to the Anesthesia Conversion Factor and the bundling of certain procedure codes that will only compound the financial strain that anesthesia groups are already facing. The proposed rule has a 60-day comment period and is expected to be published in the federal register on July 11, 2022. Final regulations will be issued on or around November 1 and unless otherwise noted, policies will be effective January 1, 2023.

ASA opposes these additional Medicare payment cuts included in the CY 2023 PFS proposed rule. The proposed rule underscores how the Medicare payment system is broken, especially during a time when anesthesia groups are faced with inflation pressures and the COVID-19 pandemic. ASA has urged and will continue to advocate to legislative stakeholders and regulatory agencies to minimize and reverse these cuts that negatively impact anesthesiologists.

Fee Schedule Provisions:

The 2023 proposed anesthesia conversion factor (CF) is 20.7191, representing a decrease of 3.91%

- There is a 0% update scheduled for the PFS in CY 2023. The Medicare Access and CHIP Reauthorization Act of 2015 established a 0% update for PFS services through 2025. Beginning in 2026, clinicians identified as qualified participants in an Advanced Alternative Payment Model will receive an annual 0.75% update, and all other clinicians will receive a 0.25% annual update.

- This negative adjustment also results from a statutorily mandated budget neutrality adjustment to account for changes in work RVUs. This means spending in one year needs to be balanced by reductions and CMS cannot increase or decrease expenditures by more than $20 million without triggering automatic budget neutrality adjustments. A funding patch passed by Congress at the end of CY 2021 expires at the end of CY 2022. This patch delayed a 3% cut to physician payment which was driven largely by updates to evaluation and management (E/M) services that were implemented in 2021.

	2022 CF	Proposed 2023 CF	Percent Change
Anesthesia	$21.5623	$20.7191	-3.91%
RBRVS	$34.6062	$33.0775	-4.42%

Specialty Impact on Anesthesia and Pain Medicine

Actual payment rates are impacted by a range of proposed policy changes related to physician work, practice expense, and malpractice RVUs. CMS summarized these changes in Table 138 in the proposed rule. Impact by practice will vary based on service mix. Specialty impacts ranged from -4% for Interventional Radiology, to +5% for Infectious Disease. The table indicates that the impact of policies in the proposed rule will have a -1% impact on anesthesiology and on interventional pain management.

Specialty	Allowed Charges (mil)	Impact of work RVU Changes	Impact of PE RVU Changes	Impact of Malpractice	Combined Impact

Anesthesiology	$1,741	-1%	0%	0%	-1%
Nurse Anesthetist/ Anesthesiologist Assistant	$1,116	-1%	0%	0%	-1%
Interventional Pain Management	$924	-1%	-1%	0%	-1%

**Note: Combined Impact may not equal the sum of work, PE and malpractice due to rounding.*
Source: Table 138, CY 2023 Proposed PFS, display copy

Pain Medicine Code Updates

Pain medicine physicians are likely to see a decrease in certain payments based upon an emerging trend to bundle payments for procedures with imaging. CPT codes 64415, 64416, 64417, 64445, 64446, 64447 and 64448 describe only injection of an anesthetic agent in the area of the peripheral nerve and/or catheter placement for postoperative pain management. In recent years these codes are frequently reported (over 75% of the time) with imaging (76942 ultrasound imaging). Due to the frequent reporting of imaging, these codes were identified by the CPT Editorial Panel and the RVS Update Committee (RUC) to be revised and imaging was bundled into the procedure codes. These codes will be effective January 1, 2023, and CMS has proposed new values for these services.

ASA is reviewing these proposals and will advocate on behalf of members to CMS that pain medicine services are appropriately and fairly-valued.

The table below reflects CMS's proposed reduced work RVUs for the new bundled codes as compared to when the procedure and imaging are billed separately.

Code	**Descriptor ***	**2022 wRVU**	**2023**

64415	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, including imaging guidance, when performed	2.02	1.35
64416	Injection(s), anesthetic agent(s) and/or steroid; brachial plexus, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed	2.15	1.65
64417	Injection(s), anesthetic agent(s) and/or steroid; axillary nerve, including imaging guidance, when performed	1.94	1.31
64445	Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, including imaging guidance, when performed	1.67	1.28
64446	64446 Injection(s), anesthetic agent(s) and/or steroid; sciatic nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed	2.03	1.64
64447	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, including imaging guidance, when performed	1.77	1.34
64448	Injection(s), anesthetic agent(s) and/or steroid; femoral nerve, continuous infusion by catheter (including catheter placement) including imaging guidance, when performed	2.08	1.68

**Updated code description for 2023 to include imaging*

CMS Proposed Chronic Pain Management (CPM) Codes

In a follow-up to a request for information (RFI) in the CY 2022 PFS proposed rule, CMS is proposing the creation of two codes for chronic pain management. In acknowledgement of the

Code	Descriptor *	2023 Proposed wRVU
GYYY1	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 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, and communitybased 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 GYYY1, 30 minutes must be met or exceeded.)	1.45
GYYY2	*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 GYYY1). (When using GYYY2, 15 minutes must be met or exceeded.)*	0.50

Anesthesiologists continue to face financial pressures beyond these reductions. Medicare payments, including physician services, are also subject to across-the-board cuts due to federal budget rules. Last year Congress passed legislation that defers until 2023 cuts of 4% that were otherwise scheduled to be implemented in 2022. Mandated by the "Pay-As-You-Go Act of 2010," these cuts were meant to offset increases in the federal deficit. A 2% across the board cut to all Medicare payments known as "Medicare Sequestration" which were waived throughout most of the pandemic public health emergency have begun to be phased back in first at 1% on April 1 and then fully implemented to 2% on July 1. Absent Congressional action, the 2% reduction will continue in 2023. Congressional action is needed to reduce or fully waive all of these cuts.

ASA is committed to advocating for changes to the broken Medicare payment system and ensure

and cause continued decreases in CFs. ASA looks forward to advocating our position before Congress and in working with CMS and other government stakeholders on proposed solutions

Please contact advocacy@asahq.org with any questions related to the Medicare Physician Fee Schedule.

Quality Payment Program Provisions:

CMS also released its 2023 Quality Payment Program (QPP) Proposed Rule. The proposed rule provides details on how CMS intends for eligible clinicians and groups to participate in the Merit-based Incentive Payment System (MIPS), Alternative Payment Models and other features of the QPP during the 2023 performance year.

Since the start of the COVID-19 pandemic, CMS has provided near blanket hardship exemptions to groups required to participate in the Merit-based Incentive Payment System (MIPS). Although blanket exemptions may provide widespread burden relief, they nonetheless discourage quality improvement at the local and national level. The continued use of hardship exemptions has resulted in far fewer positive payment adjustments, even for high-performing groups. Such actions have reduced the available payouts for groups exceeding the performance threshold. In recent years, groups performing well in MIPS have never seen a payment increase of more than 1.88%.

For the 2023 reporting year:

- CMS is proposing to maintain the performance threshold at 75 points. Scoring above 75 points would allow an individual or group a payment bonus while scoring below 75 points would result in a payment penalty in 2025. The exceptional performance bonus is not available for the 2025 payment year.

- By law, the quality performance category will be weighted at 30% and the cost performance category will be weighted by 30%. Promoting interoperability and Improvement Activities performance categories will maintain their respective 25% and 15% weights.

- CMS proposes to increase the data completeness threshold to 75% for 2024 and 2025 performance periods. The threshold in the MIPS Quality Performance Category remains at 70% for 2023 performance year.

- CMS has proposed to remove MIPS 76 (Prevention of Central Venous Catheter (CVC) – Related Bloodstream Infections) from MIPS and the Anesthesiology Measure Set. CMS has proposed the inclusion of a new measure, Screening for Social Drivers of Health in the measure set. No other change were made to the Anesthesiology Specialty Measure set.

For more information on the Quality Payment Program, please contact the ASA Department of Quality and Regulatory Affairs (QRA) at qra@asahq.org.

ASA leaders and staff will review the rule and submit comments by the deadline. Unless otherwise notes, finalized provisions will become effective January 1, 2023.

For more Information:

Proposed rule

Medicare PFS Proposed Rule fact sheet

QPP fact sheet