HEALTHCARE REGULATORY ROUND-UP - Episode #40

2023 Medicare Physician Fee Schedule Final Rule: Part II

December 14, 2022

Agenda

1. Evaluation and Management (E/M) Services
2. Split/Shared Visits
3. Practice Expense Calculations/Medicare Economic Index
4. Behavioral Health Expansion
5. Request for Information (RFI)
    1. Global Surgical Package Valuation
    2. Dental and Oral Health Services
6. Resources

Introductions

Valerie Rock, CHC, CPC
vrock@pyapc.com
Principal, Healthcare Consulting

pyapc.com
800.270.9629

ATLANTA | CHARLOTTE | HELENA | KANSAS CITY | KNOXVILLE | NASHVILLE | TAMPA

1. Evaluation and Management (E/M) Services

E/M Overview

1. CPT policy
2. CMS clarification
   - Exception
   - New vs. established policy
3. CMS wRVU Valuation

E/M Services – Office and Other Outpatient

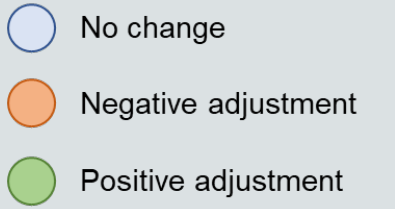
CPT Policy	CMS Policy	CMS Valuation
• Adopted 2021 Guidelines in 2021 Final Rule • Medically appropriate history and/or exam is required and should be documented in support of hospital CoPs and other reimbursement or regulatory requirements.	• **See:** *Medicare Claims Processing Manual and Medicare Benefit Policy Manual* • **See:** *Medicare Administrative Contractor E/M guidance*	• Significant increase in work RVUs during transition which impacted the entire fee schedule. • This shift is still being felt in 2023 due to delays in the adjustments due to COVID.

E/M Services – 2023 General

CPT Policy	CMS Policy	CMS Valuation
• Adopting new CPT guideline for E/M coding: • "…a continuous service that spans the transition of two calendar dates is a single service and it reported on one date, which is the date the encounter begins. If the service is continuous before and through midnight, all the time may be applied to the reported date of the service." • Definition of initial service for CPT includes subspecialty.	• Per diem concept, crossing a midnight, is not intended to conflict with the 8 to 24-hour rule. • CMS does not acknowledge subspecialties, so initial service should be limited to different specialties.	• wRVU adjustments on Other E/M codes range from -48% (99281) to +32% (99316, 99231) • Considering the -4.5% adjustment to the CF, overall impact estimated to range from -3% for Interventional Radiology to 4% for Infectious Disease • Individual providers and groups of providers will see varying impacts based on utilization and coding changes.

E/M Services – Hospital Inpatient

CPT Policy	CMS Policy	CMS Valuation

• CMS adopted the 2023 E/M guidelines to include:
  • New descriptor times
  • Medical decision making (MDM)
  • Certain time guidelines
  • Choice of MDM or time in the level selection
  • Elimination of history and exam requirements
• CPT revised the inpatient visit codes to include observation services:
  • Allows for the billing of an outpatient E/M and an inpatient/observation service on the same date
	• Bundling an outpatient E/M into inpatient E/M on same date:
	  • CMS will allow the obs/inpatient to be billed on the following day, even if less than 24 hours from the office visit
	• Swing beds, hospital or nursing facility, are billed based on place of service.
	• A transition from observation status to inpatient status does not constitute a new stay.
	• Only the provider responsible for discharge can bill a discharge code 99238-99239, others should bill subsequent hospital visit codes 99231-99233.
		99221 Initial hospital care -15%
		99222 Initial hospital care 0%
		99223 Initial hospital care -9%
		99231 Subsequent hospital care 32%
		99232 Subsequent hospital care 14%
		99233 Subsequent hospital care 20%
		 

E/M Services – Observation

CPT Policy	CMS Policy	CMS Valuation

• CMS adopted the 2023 E/M guidelines to include:
  • New descriptor times
  • MDM
  • Certain time guidelines
  • Choice of MDM or time in the level selection
  • Elimination of history and exam requirements
• CPT deleted observation section and included it in the inpatient visit section:
  • Allows for the billing of an outpatient E/M and an inpatient/observation service on the same date
	• Bundling an outpatient E/M into observation E/M on same date:
	  • CMS will allow the obs/inpatient to be billed on the following day even if less than 24 hours from the office visit
	• CMS will maintain the 8 – 24-hour rule for observation care (and applied to inpatient services):
	  • **< 8 hours (same or different day):** Initial hospital service 99221-99223
	  • **8 + hours (same day):** Same day admission and discharge 99234-99236
	  • **8+ hours (different day):** Initial hospital for date of admission 99221-99223, and hospital discharge 99238-99239 on subsequent date
	  • Note: A 24-hour stay is not required to bill the same day admission or discharge services to be billed.
		• wRVU values of initial and observation codes were fairly similar depending on the code.
		• Now, overall, the valuation is lower for the initial level 1 and 3 codes, but effectively the same for level 2 (99222).
		• However, there is a 14-32% increase in wRVU value for the subsequent codes when compared to prior year, mimicking the adjustment for inpatient.

E/M Services – Emergency Department (ED)

CPT Policy	CMS Policy	CMS Valuation

• CMS adopted the 2023 E/M guidelines to include:
  • New descriptor times
  • MDM
  • Certain time guidelines
  • Choice of MDM or time in the level selection
  • Elimination of history and exam requirements
• Will continue to allow ED and CC to be billed on same day
• ED visits do not have a reported time, so will be coded on MDM only
  • 99281 Nurse visit in the ED
  • 99282 Straightforward
  • 99283 Low
	• Clarifies that documentation must indicate that the ED service was provided before the critical care service
	• If ED physician requests patient's physician to come in and determine if the patient should be admitted, the patient's physician should report initial hospital care visit if placing in observation or admitting to inpatient.
	  • ED physician bills ED code
	• Not dropping policy on same-day critical care and ED visits
		• CMS did not agree to reduced value of 99284, so:
		  • Maintaining values for 99282-99284, but reducing 99281
		  • Now a nurse visit code: .48 to .25

ED Crosswalk

MDM Level	2022 Code	2022 MDM Level	2023 Code	2023 MDM Level	Variance
Straightforward	99281	0.48	99282	0.93	94%
Low	99282	0.93	99283	1.60	72%
Moderate	99283	1.60	99284	2.74	71%
Moderate	99284	2.74	99284	2.74	0%
High	99285	4.00	99285	4.00	0%

12.2%

87.8%

1) 2022 and 2023 CPT
2) 2022 and 2023 MPFS, Final Rule
3) 2022 E/M Bell Curve, Emergency Department (2020 Medicare Data)

E/M Services – Skilled Nursing Facility (SNF)/Nursing Facility (NF)

CPT Policy	CMS Policy	CMS Valuation
• CMS adopted the 2023 E/M guidelines • An office visit or ED visit on the same day as NF initial assessment may be billed separately. • NPP may bill an initial NF code if the initial comprehensive can be performed by the NPP per the State. • NPP can bill subsequent NF service prior to the federally mandated initial NF comprehensive assessment by the admitting physician. • NPP is considered in the same specialty as the physician in the same group. One initial service can be billed per specialty per admission.	• An office visit or ED visit on the same day as NF initial assessment cannot be billed together. • Swing beds, hospital or NF, are billed based on place of service. • Since CMS does not recognize subspecialties, it will not allow different subspecialists of the same group to bill initial NF visits.	• RUC valuation for NF codes were adopted by CMS after an explanation of the different values of the top initial and subsequent codes having the same 45-minute descriptor • CMS accepted the AMA's planned deletion of the annual NF assessment visit code 99318 • Anticipated to be billed as 99309 85% of the time which is 1.92 vs the 1.71 value of the current code

E/M Services – Home or Residence

CMS Adopts CPT Policy	CMS Policy	CMS Valuation

• CMS adopted the 2023 E/M guidelines to include:
  • New descriptor times
  • MDM
  • Certain time guidelines
  • Choice of MDM or time in the level selection
  • Elimination of history and exam requirements
• Adopting deletion of domiciliary, rest home, custodial care services (99324-99328 and 99334-99337) and merging them into home or residence services codes (99341, 99342, 99344-99345, 99347-99350) – MDM and time based
• Deleted home visit code 99343 (same MDM level as 99344) (+13%)
	• *No further refinements.*	

99341	Home visit new patient	-1%
99342	Home visit new patient	9%
99344	Home visit new patient	-15%
99345	Home visit new patient	-5 %
99347	Home visit established patient	-10%
99348	Home visit established patient	-4%
99349	Home visit established patient	5%
99350	Home visit established patient	10%

Negative adjustment

Positive adjustment

E/M Services – Prolonged Service

CPT Policy	CMS Policy	CMS Valuation

• CPT created codes to replace deleted codes 99356 and 99357 with:
  • *99418 Prolonged IP/Obs E/M ea 15 min*
  • *With and without direct patient contact*
  • *Billed on the highest level of service in the setting*
  • *Met once surpass the minimum time in the CPT descriptor by 15 minutes.*
	• CMS to released Prolonged Service G-codes:
	  • G2212 office or other outpatient services
	  • G0316 inpatient and observation care services
	  • G0317 nursing facility services
	  • G0318 home/residence services
	  • *With or without direct patient contact*
	  • *Each additional 15 minutes by the physician or qualified healthcare professional,*
	  • *Beyond the maximum required time using total time*
	  • **Time based on Physician Time File, rounded to the nearest 5 minutes and not per the CPT descriptor.**
		• 99418 = 0.81
		• G2212, G0316-8 = 0.61

E/M Services – Critical Care

CMS Adopts CPT Policy	CMS Policy	CMS Valuation
• 2021 E/M guideline changes created the need for the 2022 revision.	• CMS revised split/shared guidelines for critical care to be time based in 2022. • While hospital time requirements for other E/M visits are delayed, these are not. • Requires 104 minutes for 99292.	• Results in up to 15% cut in Medicare revenue if APPs are now the billing provider. • Impact to leasing contracts, supervision and physician and APP compensation.

2. Split/Shared Visits

Split/Shared…Delay of Time Requirement

- CMS finalized a one-year delay of the split/shared visits policy finalized in CY 2022 (with a few exceptions).
- For CY 2023, clinicians will continue to have a choice of history, physical exam, MDM, or more than half of the total practitioner time spent to define the substantive portion, instead of using total time to determine the substantive portion.
  - "Therefore, the proposed paragraph would specify, for visits other than critical care visits furnished in calendar year 2022 and 2023, substantive portion means **one of the three key components (history, exam or MDM)** or more than half of the total time spent by the physician and NPP performing the split (or shared) visit."
- Analyze financial impact for time-based billing applied to hospital services and give feedback to CMS and specialty societies regarding impact in reimbursement, compensation models, collaboration and team approach, etc.
- Use critical care outcomes in 2022, if available to also communicate impact of policy.
- **Note:** Critical care changes are <u>not</u> delayed, and CMS corrected its error in the guidelines and reiterates that the full 30 minutes must be met to bill for the 99292 (104 minutes).

Split/Shared Documentation

- Documentation in the medical record must identify the physician and NPP who performed the visit.
- The individual who performed the substantive portion of the visit (and therefore bills for the visit) must sign and date the medical record.
- For all split (or shared) visits, one of the practitioners must have face-to-face (in-person) contact with the patient, but it does not necessarily have to be the physician, nor the practitioner who performs the substantive portion and bills for the visit. The substantive portion can be entirely with or without direct patient contact, and is determined by the proportion of total time, not whether the time involves patient contact.
- Modifier -FS (Split or Shared E/M Visit) must be reported on claims for split (or shared) visits, to identify that the service was a split (or shared) visit.

Source: https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/clm104c12.pdf

Split/Shared Analysis

"When one of the three key components is used as the substantive portion in 2022, the practitioner who bills the visit must perform that component in its entirety in order to bill. For example, if history is used as the substantive portion and both practitioners take part of the history, the billing practitioner must perform the level of history required to select the visit level billed. If physical exam is used as the substantive portion and both practitioners examine the patient, the billing practitioner must perform the level of exam required to select the visit level billed. If MDM is used as the substantive portion, each practitioner could perform certain aspects of MDM, but the billing practitioner must perform all portions or aspects of MDM that are required to select the visit level billed." - *MCPM Ch. 12, S. 30.6.18*

E/M Guidelines effective 2023 for Facility E/M Codes:

History and/or Examination ►E/M codes that have levels of services include a **medically appropriate** history and/or physical examination, when performed. The nature and extent of the history and/or physical examination are determined by the treating physician or other qualified health care professional reporting the service. The care team may collect information, and the patient or caregiver may supply information directly (eg, by electronic health record [EHR] portal or questionnaire) that is reviewed by the reporting physician or other qualified health care professional. The extent of history and physical examination is not an element in selection of the level of these E/M service codes.◄

1) MCPM Ch 12 Section 30.6.18
2) https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf

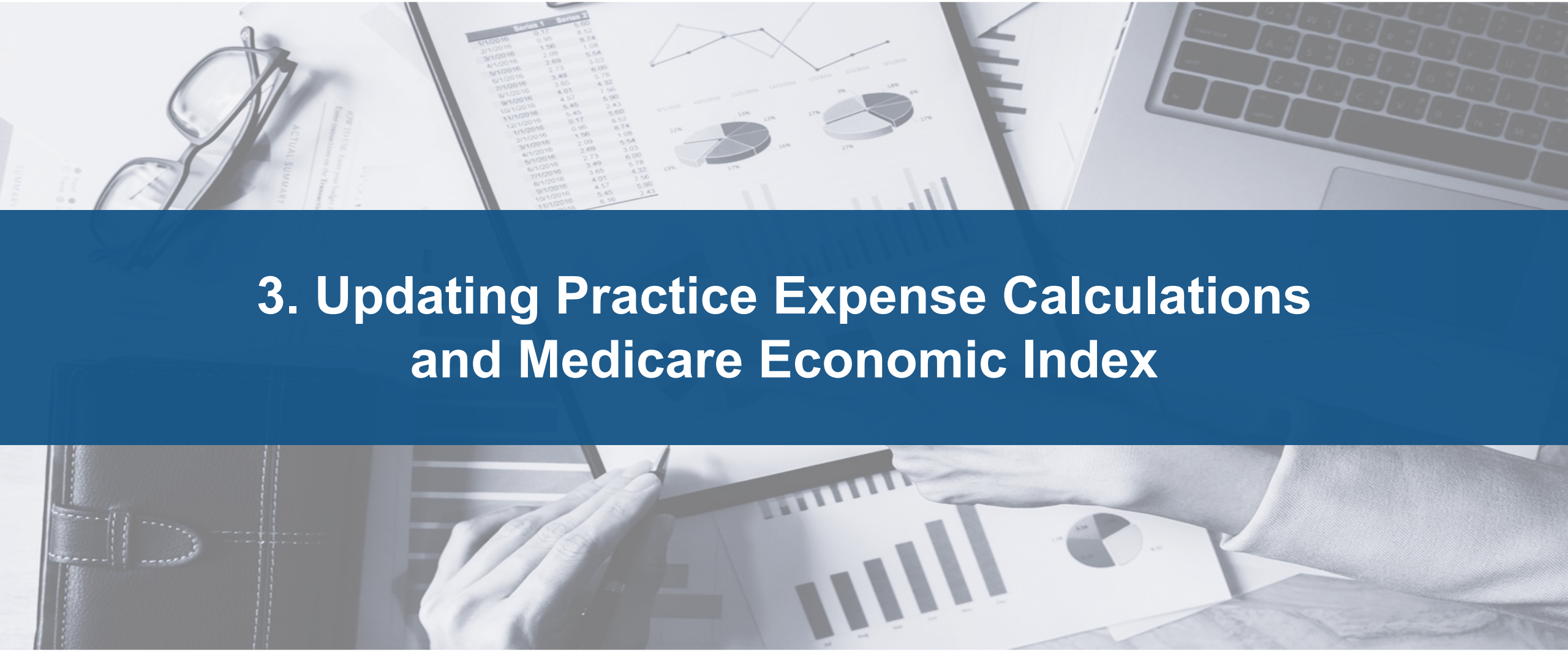
Substantive History or Exam

- “Given the proposed delayed implementation of our substantive portion policy until CY 2024, our current policy remains in place.
- As such, when an E/M visit requires a **medically appropriate** history and/or physical exam, in accordance with its code descriptor, these service element(s) can qualify as the substantive portion, when performed.”

Source: MPFS 2023 Final Rule

Split/Shared Analysis

Key Components	2022 Final Rule	2023 Final Rule	New E/M Guidelines	Objective/ Subjective in 2023
History	Complete per 95/97 GL	Complete per 2023 GL	Medically Appropriate	Subjective
Exam	Complete per 95/97 GL	Complete per 2023 GL	Medically Appropriate	Subjective
MDM	Complete per 95/97 GL	Complete per 2023 GL	Per 2023 GL Quantification	Objective
Time	>50% per New E/M GL	>50% per 2023 GL	>50% per 2023 GL	Objective



3. Updating Practice Expense Calculations and Medicare Economic Index

Practice Expense Calculations

- Implementing second year of clinical labor pricing update.
- CMS seeks comment on identification of the appropriate instrument, methods, and timing for updating specialty-specific PE data that foster transparency and address market trends
- Maintained the use of the 2006-based MEI cost share weights for the CY 2023 GPCIs
  - Requesting comment from the public regarding these inputs as well

Medicare Economic Index (MEI)

- CMS finalized to rebase and revise the MEI for 2023
- Current MEI weights are based primarily on results from the AMA's PPI survey, based on 2006 data
- Will use of the 2017-based MEI cost weights with technical revisions for certain cost components
- CY 2023 MEI update is 3.8 percent – based on data through Q2 2022 of the 2017-based MEI
- Will result in substantial impact to physician payments – changes to distribution
- Not implemented this year nor applied to 2023 rate setting

4. Behavioral Health

Behavioral Health Services Expansion

- CMS proposes:
  - To expand access by permitting behavioral health services to be furnished by licensed professional counselors, marriage and family therapists, and other types of practitioners under **general supervision** instead of direct supervision when these services are incident to the services of a physician or non-physician practitioner
  - To pay for behavioral health integration service personally performed by clinical psychologists (CPs) or clinical social workers (CSWs) when provided as a part of a primary care team
  - Pay for Opioid Treatment Programs
    - Which provide services in mobile units
    - Which initiate treatment with buprenorphine via telecommunications
  - Monthly payment for comprehensive treatment and management of chronic pain (CPM)
    - G3002 Monthly bundle, first 30 minutes
    - G3003 each addl 15 minutes (max 3)

5. Request for Information (RFI)

RFI – Global Surgical Package Valuation

- CMS seeks stakeholder input on strategies for paying more accurately for the global surgical packages based on changes in healthcare delivery over the last several years.
- Options proposed:
  - "(1) revaluing all 10- and 90-day global packages at one time (perhaps with staggered implementation dates);
  - (2) revaluing only the 10-day global packages (because these appear to have the lowest rate of postoperative visit performance, per RAND's analysis of claims data);
  - (3) revaluing 10-day global packages and some 90-day global packages (such as those with demonstrated low postoperative visit performance rates as identified in RAND's analysis of these services); or
  - (4) relying on the Potentially Misvalued Code process to identify and revalue misvalued global packages over the course of many years."
- Comments by the public reflect no consensus on the issue or strategy for valuing globals.

RFI – Dental and Oral Health Services

- **Current:** CMS codified Medicare Parts A and B payment policies on dental services, such as those integral to treatment of a medical condition. Will continue to be carrier priced until data is sufficient to develop PPS rates.
  - *Examples:*
    - Reconstruction of the jaw following accidental injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams preceding kidney transplantation
    - Dental exams and necessary treatments prior to organ transplants, cardiac valve replacements, and valvuloplasty procedures that may be inextricably linked to, and substantially related and integral to, the clinical success of an otherwise covered medical service

- **Future:** CMS is requesting recommendations for identifying similar circumstances:
  - "To facilitate our consideration of interested parties' recommendations within an annual rulemaking cycle, we requested that interested parties submit this information by **February 10th** of that year at MedicarePhysicianFeeSchedule@cms.hhs.gov."

Source: https://public-inspection.federalregister.gov/2022-23873.pdf

Final Rule Effective Date

January 1, 2023

6. Resources

Resources

- https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule
- https://public-inspection.federalregister.gov/2022-23873.pdf
- https://www.cms.gov/newsroom/press-releases/hhs-finalizes-physician-payment-rule-strengthening-access-behavioral-health-services-and-whole
- www.ama-assn.org/cptevaluation-management

Our Next Regulatory Round-Up

- 2023 Medicare Physician Fee Schedule Final Rule, Part III – January 11
  - Quality Payment Program, including the Merit-Based Incentive Payment System (MIPS) and Advanced Alternative Payment Models (APMs)

How can we HELP?

A national healthcare advisory services firm providing consulting, audit, and tax services