2023 Physicians Medicare Reimbursement Cut and New Shared Service Rules

Michael A. Cassidy, Esquire

The Centers for Medicare and Medicaid Services (CMS) issued the "final rule" https://www.cms.gov/newsroom/fact-sheets/calendar-year-cy-2023-medicare-physician-fee-schedule-final-rule for the 2023 Medicare Physician Fee Schedule on November 1, 2022. The document is almost 3,000 pages long, and covers countless topics in exhaustive detail, but for purposes of this article we are going to focus on just two:

1. The physician pay cut imposed by the Medicare Conversion Factor reduction, and

2. The final shared/split service billing rules.

Physician Pay Cut

As most of you already know, Medicare physician payments are primarily based on the relative value units assigned to each Medicare covered service by CMS, i.e.:

1. Work relative value units (WRVUs)

2. Malpractice expense units

3. Practice overhead units

The units are added together and multiplied by the Medicare conversion factor, i.e., a dollar value determined by CMS to arrive at the total payment for each service. Just as an aside, for productivity purposes, most employers and hospital systems measure productivity based on just the WRVUs, excluding the other two components.

The WRVU system was implemented by CMS in 1992, and it has always contained a mechanism for determining total Medicare payments. Since that time, there has been a constant struggle to control the total Medicare physician expenditures within a budget risk corridor, and the governing factor was the Sustainable Growth Rate (SGR) budget process, which was designed to decrease the dollar value of the conversion factor if physician volume exceeded the budget projections and increase the conversion factor if total volume was below the corridor parameters.

As might be expected, once each service was paid based totally on volume, then volume increased faster than projected, especially when hospital systems began mandating WRVU productivity thresholds and paying incentives and bonuses based upon WRVU production. The ever increasing expense is one of the reasons many systems are now continuing to quality-based payments rather than pure volume-based payments.

Some of you may recall the almost constant annual battle in which Congress postponed the impending physician fee schedule cut, because of the unacceptable reductions baked into the Sustainable Growth Rate formula. The annual decisions to postpone the required SGR reductions resulted in ballooning future pay cuts. The SGR was finally repealed in 2015, at which time the projected pay cut would have been 27.4 percent, and replaced by a new formula designed to pay productivity incentives when combined with identified quality factors.

However, the budget sequesters mandated by the 2010 Statutory Pay-As-You-Go-Act (PAYGO) coupled with the impact of the passage of the $1.9 Trillion COVID-19 relief package in the American Rescue Plan has raised new problems.

For 2023, CMS is proposing a decrease in the conversion factor from $34.61 per unit to $33.06 per unit; this is a reduction of $1.55 per WRVU, which is approximately a 4.5 percent decrease, across the board for all specialties. CMS attributes the reduction to a combination of the "statutorily required CY 2023 update of 0 percent" and the expiration of last year's "5 percent stopgap" measure.

Just as in past years, organized medicine is lobbying lawmakers to postpone these reductions. The AMA immediately issued a statement labeling across-the-board reductions as an "ominous reality". However, as already demonstrated by past experience, simply postponing the

reductions only exacerbates the future reckoning. Repealing SGR in 2015 was touted as the "permanent fix".

Shared or Split Service Billing

CMS first proposed to recognize split E&M visits in facility settings, when part of the service is performed by both a physician and a non-physician practitioner (NPP) who are both of the same group, in July of 2021. Although CMS delayed the implementation of this rule for 2022, the 2023 Medical Physician Fee Schedule (MPFS) proposes to implement the shared visit billing for 2023 and thereafter.

The essence of the rule is that an E&M visit in a facility is to be billed as performed by the practitioner, i.e., either MD or NPP, who provided the substantive portion of the service, and the responsible billing entity can choose to define substantive performance based upon either (1) time or (2) the practitioner that performed the medical decision making, the physical exam, or the history and physician, based upon whichever of those components selected by the billing entity as the indicator of the substantive portion.

Note that this applies only in facility settings; billing in the office setting allows 3 separate circumstances in which shared services might occur:

1. By the physician when performed by the physician,
2. By the physician and any other qualified person in the physician's office if performed in accordance with the incident to rules, i.e. the physician is physically present in the office to supervise and take over the care of the case if necessary, and
3. By a nurse practitioner or physician assistant at 85% of the physician fee schedule.

Physicians employed by systems which also provide NPP coverage, as most do, must be aware of the impact on their individual productivity when the system elects to be facility E&M services as if performed by the NPP. Furthermore, the shared service rules ostensibly require that physicians and NPPs practicing in facilities must be treated as being in the same group in order to provide and bill for shared services.

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Special Issue

Coverage of the final 2023 Medicare physician fee schedule and Quality Payment Program

1 **Physician payments**
Pay cuts looming, advocacy groups turn to lawmakers for reprieve

3, 4, 7 **Coding**
CMS poised to accept most 2023 E/M revisions, with a few asterisks
CMS creates 3 new prolonged codes, won't assign frequency limits
Prolonged service threshold chart

5 **Benchmark of the week**
Most specialties projected to lose charges in 2023: Fee schedule

7 **Billing**
CMS extends its split/shared exception for facility-based visits

8 **Quality Payment Program**
QPP changes arrive, as later reporting, payment hassles loom

10 **Shared Savings Program**
Shared Savings offers rewards for ACOs in underserved areas, but others can benefit

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Physician payments

Pay cuts looming, advocacy groups turn to lawmakers for reprieve

The final 2023 Medicare physician fee schedule that CMS released Nov. 1 confirmed a harsh reality: Medical groups will see a 4.5% cut to the conversion factor (CF) on Jan. 1, 2023, as the CF falls to a rate of $33.06 and sends some charges under the Part B payment system tumbling (PBN blog 11/1/22).

The $33.06 CF rate comes in $1.55 less than the CY 2022 rate of $34.61. The anesthesia CF also will drop 4.4% in 2023, taking a cut from the CY 2022 rate of $21.56 to $20.61 in CY 2023, a reduction of $0.95 year over year.

Not all specialties will bear the brunt of the CF reduction equally, as CMS' yearly effort at revising misvalued codes alters the contribution of relative value units (RVU) to the final payment picture. Final fees are a product of RVU inputs — practice expense, malpractice and work — multiplied by the CF.

Medical practices faced a similar situation only a year ago, when CMS finalized a 4% cut to the CF for CY 2022. However, lawmakers intervened to roll back the CF reduction, as well as planned sequester and PAYGO cuts (PBN blog 12/10/21). Advocacy groups are now urging members of Congress to again forestall the Part B payment decreases.

Within an hour of the rule's Nov. 1 release, the AMA issued a statement from President Jack Resneck Jr., M.D., stating that the "payment schedule released today puts Congress on notice that nearly 4.5 percent across-the-board reduction in payment rates is an ominous reality unless lawmakers act before Jan. 1."

Prepare for 2023 Part B changes

Get ready for a host of regulatory updates to the Medicare Part B ecosystem: key coding and billing changes, fluctuating fees, split/shared revisions, specialty impact, and more. To ensure your practice's continued success, attend the Dec. 12 webinar **2023 Physician Fee Schedule: Adapt to E/M Changes, Fee Updates, and More** and hit the ground running as soon as these updates take effect on Jan. 1. Learn more: https://codingbooks.com/ympda121222.

Continued on Page 34

From Page 33

The finalized pay cuts would sow "financial instability" within the Part B payment system and threaten access to care, Resneck said.

On Nov. 2, the American College of Physicians echoed those remarks. "Medicare payments to physicians have been held flat for years, amounting to a significant decrease when accounting for inflation and the rising cost of running a medical practice," said Ryan D. Mire, M.D., MACP, ACP president in a statement. "The significant payment cuts that are scheduled for next year must be prevented in order to ensure that medical practices are able to remain open and physicians are able to work with Medicare beneficiaries."

Is intervention still a possibility this year? "Due to the dire nature of these cuts combined with the potential effect of the 4% PAYGO sequestration, we feel confident that Congress will take steps to mitigate these cuts," says Claire Ernst, director of government affairs with the Medical Group Management Association (MGMA) in Washington, D.C. "That being said, we are not taking our foot off the gas in advocating on this issue until we see something passed into law — preferably before the end of the year."

Revaluing services in the PFS

In the final rule, CMS addressed a key component of pay rates — work RVUs — for more than 160 new, revised or potentially misvalued codes across a range of procedures and E/M services. For instance, the agency set work RVUs for a series of anterior hernia repair codes, **49591-49596** and **49613-49618**, as well as parastomal repair codes **49621-49622**. The work RVUs range from 5.96 for an initial repair less than 3 cm to 22.67 for a recurrent repair greater than 10 cm.

As the agency agreed to the new reporting format for other E/M services outside of the office setting, it revamped work RVUs across a range of services (*see story, p. 3*). The series of initial hospital and observation care (**99221-99223**), a new combined code category in 2023, will see a significant reduction in work RVUs. For instance, code 99223, corresponding to a high level of medical decision-making or 75 minutes of time, has its work RVUs chopped by 9%.

However, subsequent inpatient or observation care services (**99231-99233**) will get a big raise. Work RVUs increase by 31% for 99231; 14% for 99232; and 20% for 99233.

In the final rule, CMS notes that the AMA's RVS Update Committee (RUC) "reviewed and resurveyed" inpatient and observation care services for its January 2022 meeting, offering revised work RVUs, as well as intraservice times and total times. The agency reports that several commenters disagreed with the proposed values for initial hospital and observation care services. However, "given the reductions for total times for these codes," the agency agreed to the RUC recommendations across the board, according to the final rule.

The work RVU inputs for other non-office E/M service are up and down. Except for lowest-level emergency department code **99281**, which will see its work RVUs nearly cut in half, the remainder of the ED series

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remains flat. Three out of seven nursing facility codes (**99304-99310**) will see a reduction in work RVUs. And five out of eight home visit codes (**99341-99345, 99347-99350**) are on track for reduced work RVUs as well.

See "Table 16: CY 2023 Work RVUs for New, Revised and Potentially Misvalued Codes" for the complete list of work RVU inputs for 2023. — *Richard Scott (rscott@decisionhealth.com)*

Coding

CMS poised to accept most 2023 E/M revisions, with a few asterisks

As practices adjust to the AMA's updated E/M guidelines for visits in facilities and residential settings, Medicare won't present you with many unpleasant surprises.

CMS confirmed in the final rule that it will adopt the framework of the revised guidelines, including payment based on medical decision-making (MDM) or time. The agency will diverge from the AMA on some points, however.

Medicare will continue to not recognize subspecialties for the purposes of defining an initial vs. subsequent service. The AMA states that an initial service may be reported when the patient has not received any professional services during a facility stay from the physician or other qualified health care professional or another such practitioner of the exact same specialty and subspecialty who belongs to the same group practice. CMS does not recognize subspecialties, so the agency would not allow different subspecialists to report separate initial visits.

For non-physician practitioners (NPP), the agency finalized its proposal to have them remain their own specialties. "When advanced practice nurses and physician assistants are working with physicians, they are always classified in a different specialty than the physician," CMS noted.

That is another divergence from the AMA's 2023 E/M guidelines, which state that "when advance practice nurses and physician assistants are working with physicians, they are considered as working in the same specialty and subspecialty as the physician."

But for Medicare, the NPP policy is nothing new, explains Betsy Nicoletti, CPC, of North Andover, Mass.-based Medical Practice Consulting. "This is CMS affirming their longstanding policy," she says. Unlike private insurers, Medicare doesn't enroll NPPs to a medical or surgical specialty, she adds, so the concept of NPPs being focused on a given physician specialty doesn't apply.

On one key point, you'll find CMS and the AMA in alignment: if a patient transitions from observation to inpatient status, it does not constitute a new stay in the facility. The policy applies to both observation/inpatient and nursing facility codes. For example, when a patient is admitted to observation status and the clinician subsequently decides to admit the patient to inpatient status, it is still the same stay for the purpose of billing an initial or subsequent visit.

Observation/inpatient-specific policies

8-to-24-hour rule remains in place. CMS finalized its plan to continue to apply the 8-to-24-hour rule for the newly consolidated inpatient or observation and discharge codes to deter what the agency views as the potential for duplicative payments. That means that:

- For stays of less than eight hours, report initial hospital or observation services (**99221-99223**).
- When the hospital admission is at least eight but less than 24 hours, report same day admission and discharge from hospital (**99234-99236**).
- When a patient is admitted for more than 24 hours you should report an initial hospital/observation code for the date of admission (99221-99223) and hospital discharge day management code (**99328-99239**).

Medicare: Same-day admission at a different site not separately payable. When a patient is admitted to observation or inpatient status during a visit provided the same day in a different place of service (e.g., office, hospital ED or nursing facility), Medicare will continue to consider that visit bundled as part of the initial hospital inpatient or observation care service, CMS stated. The AMA in its 2023 E/M guidelines added a new provision that would allow separate billing (with modifier **25**) for a visit in a different setting when the decision to admit the patient was made during that visit. For Medicare, at least, that service will continue to be bundled as part of the initial observation/inpatient visit.

Medicare will continue its swing-bed policy. CMS will keep the policy that: "If the inpatient care is being billed by the hospital as inpatient hospital care, the

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