2022 Reimbursement Update

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1

ED RVUs and Reimbursement

2

RBRVS Equation

Work RVUs
Practice Expense RVUs
+Liability Insurance RVUs
Total RVUs for a given code

RVU_{Total} X Conversion Factor (CF) = Medicare Payment

3

2022 Work RVUs Stable

Code	2021 wRVU	2022 wRVU
99283	1.60	1.60
99284	2.74	2.74
99285	4.00	4.00

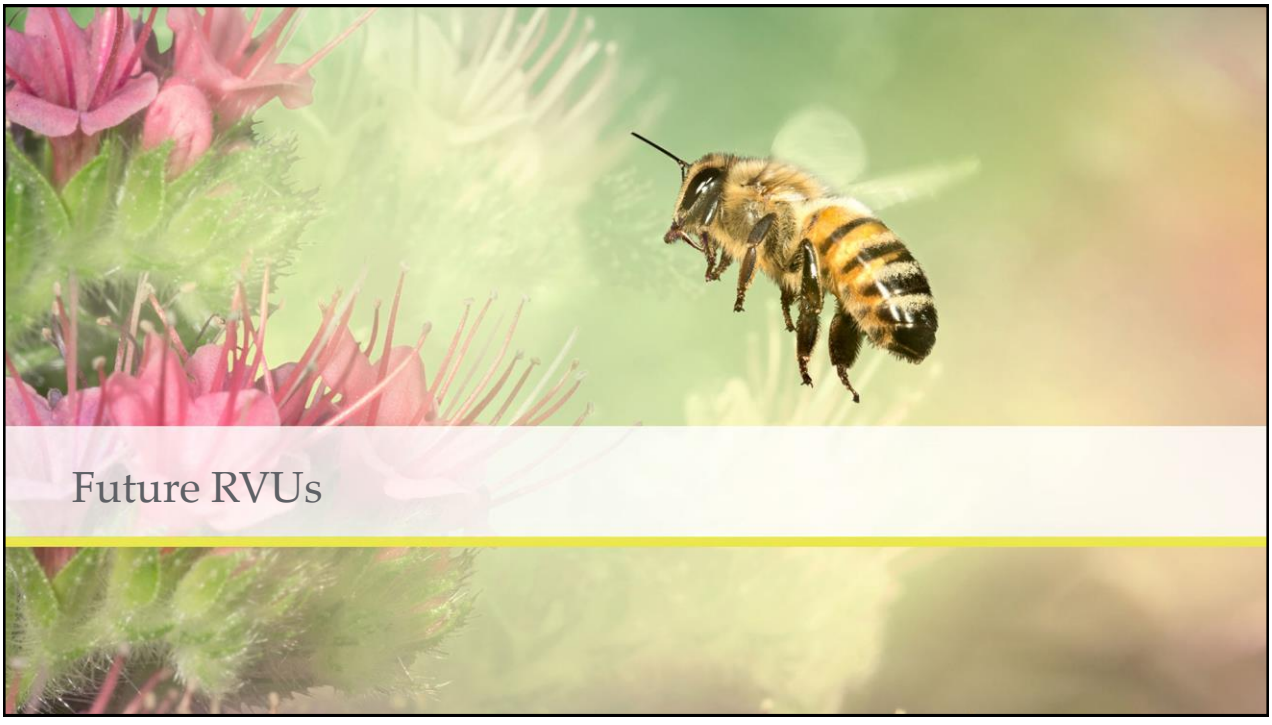
2023 RUC/CMS ED Work RVU Update

4

2022 RVU Component Detail

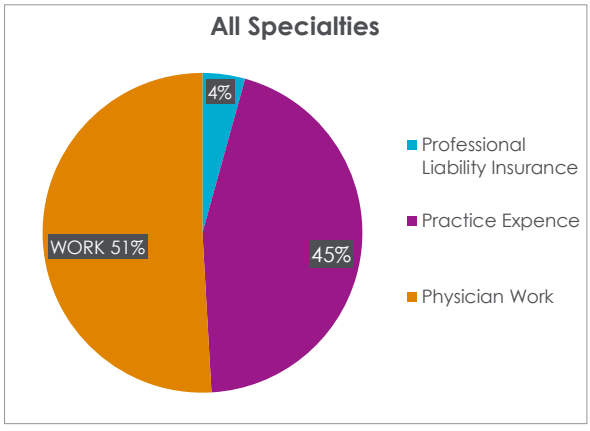
Code	2021 Work	2022 Work	2021 PE	2022 PE	2021 PLI	2022 PLI	2021 Total	2022 Total
99281	0.48	0.48	0.11	0.11	0.05	0.05	0.64	**0.64**
99282	0.93	0.93	0.21	0.21	0.10	0.10	1.24	**1.24**
99283	**1.60**	**1.60**	0.33	0.33	0.17	0.18	**2.10**	**2.11**
99284	2.74	2.74	0.54	0.54	0.29	0.28	**3.57**	**3.56**
99285	4.00	4.00	0.74	0.75	0.42	0.42	5.16	**5.17**

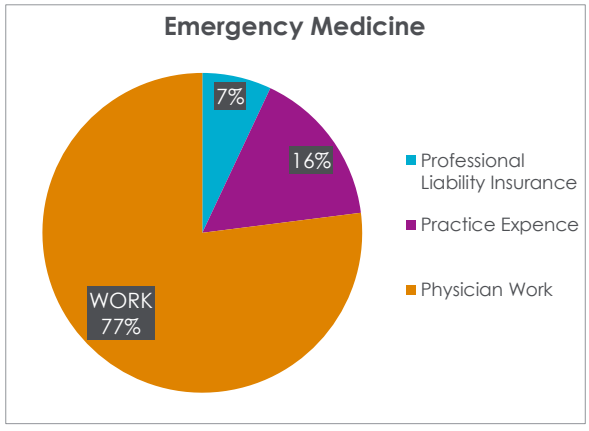
5



6

ED RVU Components: It's All about the Work RVUs





E Med has the highest percentage of Work to Total RVUs of any specialty since we have limited practice expense.

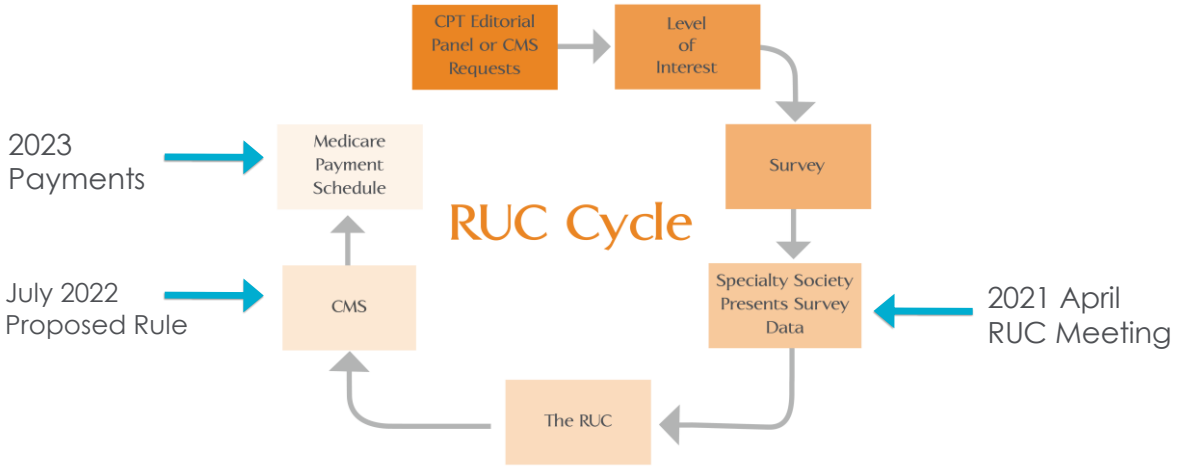
7

The ED RUC Process

- ED Work RVUs typically only reviewed as part of a large update
- Noteworthy Prior Work RVU valuations
  - 2007 big increases across the board
    - (99285 wRVU 3.06 - 3.80)
  - 2020 5% increase
    - (99283 wRVU 1.34 - 1.42)
  - 2021 5% increase
    - (99284 wRVU 2.60 - 2.74)
- 2023 ED codes being revalued again as part of the changing documentation guidelines

8

November 2021 The RUC Cycle and Next Steps for 2023



9

10

The 2022 Conversion Factor

"Section 1848 of the Act requires that increases or decreases in RVUs may not cause the amount of expenditures for the year to differ by more than $20 million. If this threshold is exceeded, we make adjustments to preserve budget neutrality."

Physician Final Rule

2020	$36.0896
2021	$32.4085 (-10.2%) *$34.8931 Final
2022	$33.5983

*Congressional Action +3.75%

TABLE 134: Calculation of the CY 2022 PFS Conversion Factor

CY 2021 Conversion Factor		34.8931
Conversion Factor without CY 2021 Consolidated Appropriations Act Provision	-3.75%	33.6319
Statutory Update Factor MACRA	0.00 percent (1.0000)	
CY 2022 RVU Budget Neutrality Adjustment	-0.10 percent (0.9990)	
CY 2022 Conversion Factor		**33.5983**

11

Making The Sausage: 2022 Conversion Factor Issues We Face

- We are starting from a 2021 CF of $34.8931
- November 2nd Final Rule $33.5983
- **3.75%** new money from Congress 2021was only for 1 year
- The **sequester** is a growing issue
  - -2% from the Balance Budget Act
  - -4% from the "pay as you go" requirements related to The American Rescue Plan ($1.9T)
- Advocacy efforts
  - Sequester -4% from pay as you go (AHA hopeful)
  - 3.75% new money goes away (AMA hopeful)
    - -2% has been in the background for 10+ yrs.

12

Medicare Payment per RVU Going Down What Is the Impact?

- Using 2020 utilization data, total RVUs change between -1 and 1% for more than 90 % of practitioners representing more than 81% of the changes with variation by specialty.
- Winners and Losers based on Table 136
  - Diagnostic Testing Facility +6%, Portable X-ray Supplier +2%
  - Interventional Radiology -5%
  - Cardiology, Hem/Onc, Nuclear Medicine, Radiology -1%
  - ED CMS *projected* 0%

13

Potential Remedies to Proposed CF Decrease

- Conversion factor changes not under CMS or HHS; decided by Congress
- *Holding Providers Harmless From Medicare Cuts During COVID-19*
  - Bera M.D. (D-CA) and Buschon M.D. (R-IN) Oppose the 3.75% cut
- Some possibility (small) next coronavirus relief package CF relief
- Kick the can without formal repeal- phased in over several years
- Formal budget neutrality waiver during the PHE or longer
- Advocacy effort underway

14

The Voices Are Loud and Strong

Congress of the United States
Washington, DC 20510

October 14, 2021

The Honorable Nancy Pelosi
Speaker of the House
U.S. House of Representatives
H-232, U.S. Capitol
Washington, DC 20515

The Honorable Kevin McCarthy
Minority Leader
U.S. House of Representatives
H-204, U.S. Capitol
Washington, DC 20515

Dear Speaker Pelosi and Leader McCarthy,

As Congress considers a framework to ensure appropriate reimbursements and improve the Medicare payment system broadly, we must act before the end of the year to avert the imminent cuts, including extending the 3.75% payment adjustment, and provide continued stability for physicians and other health care professionals.

Ami Bera, M.D.
Member of Congress

Larry Bucshon, M.D.
Member of Congress

Ami Bera M.D. Press release: Reps. Bera and Bucshon Lead Over 245 Members in Urging Action on Looming Medicare Physician Payment Cuts that will Strain Patient Access to Care.


Additional Member of Congress Signatories

247 of the 435 members of Congress cosigned the letter!

15

The Future of APP Shared Services

- Longstanding CMs policy allows Physician NPI billing if a "substantive portion" of an APP shared visit performed
- 2022 Final Rule addresses how to define "substantive portion" going forward
  - "We believe the commenters overestimate the administrative burden of tracking and attributing time, given the advent of EHRs. (YIKES)
  - "We understand that an adjustment period may be needed to establish systems to track time for shared visits, especially since the coding for E/M visits in many facility settings will not use MDM or time to distinguish visit levels until 2023." **(:<)**
  - We are finalizing our definition of "substantive portion" for shared visits as more than half of the total time spent by the physician and NPP performing the, shared visit beginning January 1, 2023." **Page 429 2022 Physician Final Rule**

16

2022 Shared Service Substantive Portion

"For 2022, except for critical care visits, the substantive portion will be defined as:

- more than half of the total time spent performing the shared visit. OR

-one of the three key components: history, exam, or MDM

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 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." **Page 423 2022 Physician Final Rule**

17

2022 Shared Service Documentation Standard

- "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…."
- A modifier will be required to identify shared services
  - Modifier detail evolving

18

2022 and 2023 ED Shared Services

Response: "Having reviewed the public comments and consulted with our medical officers, we do not believe that an alternative process for ED visits is the best approach at this time. As we discussed above, only for 2022, we will allow history, or exam, or MDM, or more than half of the total time, to comprise the substantive portion of any E/M visit (including ED visits) except critical care. Starting in 2023, the finalized listing of qualifying activities will apply to all split E/M visits except critical care, for purposes of determining the substantive portion." **Page 434 2022 Physician Final Rule**

TABLE 26: Final Definition of Substantive Portion for E/M Visit Code Families

E/M Visit Code Family	2022 Definition of Substantive Portion	2023 Definition of Substantive Portion
Other Outpatient*	History, or exam, or MDM, or more than half of total time	More than half of total time
Inpatient/Observation/Hospital/Nursing Facility	History, or exam, or MDM, or more than half of total time	More than half of total time
Emergency Department	History, or exam, or MDM, or more than half of total time	More than half of total time
Critical Care	More than half of total time	More than half of total time

19

2022 Final Rule Critical Care Policies

Critical Care and 9928X OK

"A patient might not require critical care services at the time of an ED visit, but then be admitted to the hospital on the same calendar date as the ED visit and require care that meets the definition of critical care services." **Page 462 2022 Physician Final Rule**

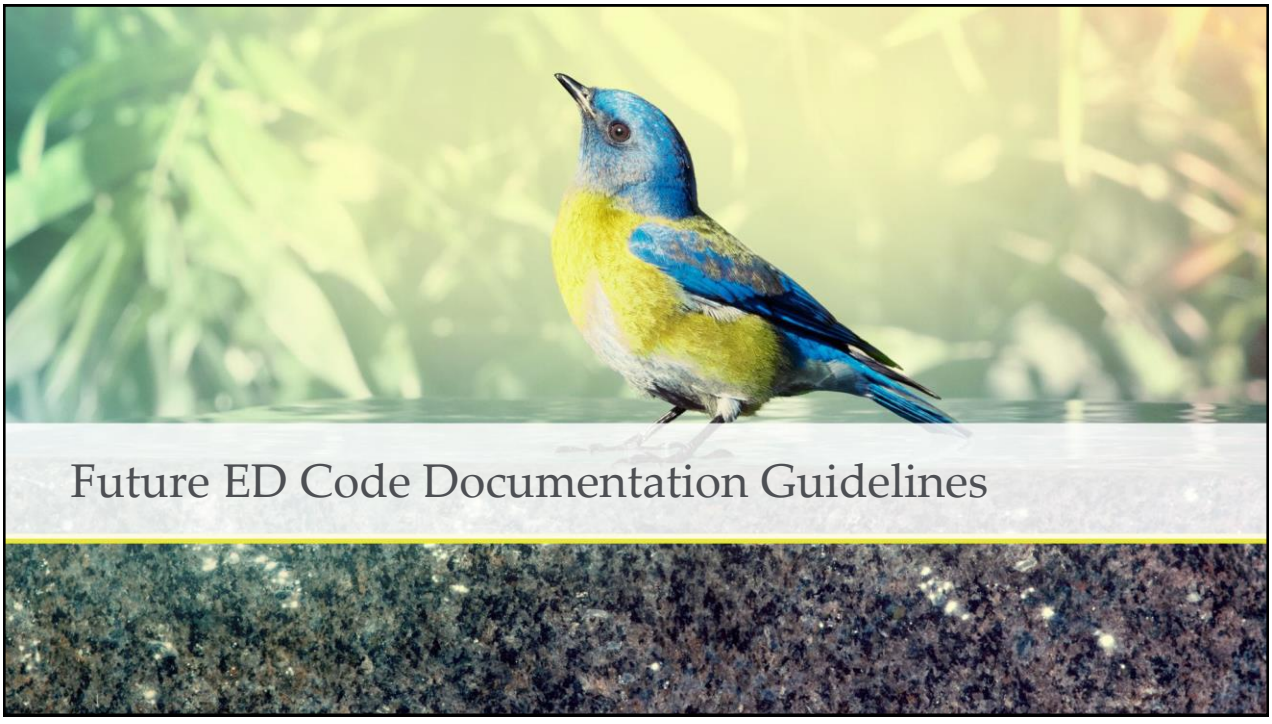
9928x Must Come First

"Specifically, as long as the physician documents that the E/M service was provided prior to the critical care service at a time when the patient did not require critical care, that the service is separate and distinct… Practitioners must use modifier -25 on the claim when reporting these critical care services." **Page 463 2022 Physician Final Rule**

Shared Critical Care with PA/NP OK

"For critical care visits, starting for services furnished in CY 2022, the substantive portion will be more than half of the total time, as proposed." **Page 431 2022 Physician Final Rule**

20



Future ED Code Documentation Guidelines

21

2021 Unified CMS AND CPT Documentation Guidelines

"***For 2021***,*office/outpatient E/M visits (CPT codes 99201-99215), we proposed generally to adopt the new coding, prefatory language, and interpretive guidance framework that has been* ***issued by the AMA/CPT*** *because we believed it would accomplish greater burden reduction.*"

Physician final rule page 868/2475

"*Therefore, we are finalizing our proposal to adopt the MDM guidelines as revised by CPT to select office/outpatient E/M visit level beginning January 1, 2021.*"

Physician final rule page 868/2475

22

Current and Future CPT Changes

►Summary of Guideline Differences◄

►Component(s) for Code Selection	Office or Other Outpatient Services	Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, Home)
History and Examination	• As medically appropriate. Not used in code selection	• Use key components (history, examination, MDM)
Medical Decision Making (MDM)	• May use MDM or total time on the date of the encounter	• Use key components (history, examination, MDM)
Time	• May use MDM or total time on the date of the encounter	• May use face-to-face time or time at the bedside and on the patient's floor or unit when counseling and/or coordination of care dominates the service. *Time is **not** a descriptive component for the emergency department levels of E/M services.*
MDM Elements	• Number and complexity of problems addressed at the encounter • Amount and/or complexity of data to be reviewed and analyzed • Risk of complications and/or morbidity or mortality	• Number of diagnoses or management options • Amount and/or complexity of data to be reviewed • Risk of complications and/or morbidity or mortality◄

23

Goals For Future ED E/M Documentation Guidelines

- Keep all five levels of ED E/M codes
  - 99283 and 99284 would share the same MDM if kept as "moderate", one would have to go.
  - Suggestion to eliminate 99281 because no MDM held off
  - History and Physical Exam would not be key elements
- Keep time out of the ED Code Descriptors
- Make the Office 2021 MDM Table more ED friendly
  - Get points for not ordering a test
  - Remove the word "external" from Review of notes bullet
  - Discussion with patient or surrogate of management options "simple" vs. "advanced"

24

2023 A Huge Year for ED Documentation Coding and Reimbursement

- 2023 likely the ED codes may be scored by MDM or time requirements
- 2023 likely new MDM guidelines for ED
- 2023 new ED RVUs
- Conversion Factor issues continue

25

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26