2022 Strategic Reimbursement Update

Michael Granovsky MD, CPC, FACEP
President, LogixHealth
ED RVUs and Reimbursement
RBRVS Equation

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

$$RVU_{\text{Total}} \times \text{Conversion Factor (CF)} = \text{Medicare Payment}$$
## 2022 Work RVUs Stable

<table>
<thead>
<tr>
<th>Code</th>
<th>2021 wRVU</th>
<th>2022 wRVU</th>
</tr>
</thead>
<tbody>
<tr>
<td>99283</td>
<td>1.60</td>
<td>1.60</td>
</tr>
<tr>
<td>99284</td>
<td>2.74</td>
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</tr>
<tr>
<td>99285</td>
<td>4.00</td>
<td>4.00</td>
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</table>
## 2022 RVU Component Detail

<table>
<thead>
<tr>
<th>Code</th>
<th>2021 Work</th>
<th>2022 Work</th>
<th>2021 PE</th>
<th>2022 PE</th>
<th>2021 PLI</th>
<th>2022 PLI</th>
<th>2021 Total</th>
<th>2022 Total</th>
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<tbody>
<tr>
<td>99281</td>
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<tr>
<td>99282</td>
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<td>0.93</td>
<td>0.21</td>
<td>0.21</td>
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<td>99285</td>
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<td>0.74</td>
<td>0.75</td>
<td>0.42</td>
<td>0.42</td>
<td>5.16</td>
<td>5.17</td>
</tr>
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</table>
2022 RVU Increases with Each E/M Level
Future RVUs
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.
The ED Relative Value Update Committee (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
The RUC Cycle and Next Steps for 2023

Nov 2022
Final Rule

July 2022
Proposed Rule

RUC Cycle

CPT Editorial Panel or CMS Requests → Level of Interest

Medicare Payment Schedule → CMS

Survey → Specialty Society Presents Survey Data

The RUC
The Conversion Factor
Medicare Conversion Factor Big Picture

BBA 1997
SGR Formula

MACRA 2015
Repeals SGR
MIPS

2021 Budget
Neutrality Triggered
Medicare's payment per RVU - The Conversion Factor considers the following:

- The number of Medicare beneficiaries
- The amount of money spent in prior years
- Changes in the regulations governing covered services

<table>
<thead>
<tr>
<th>Year</th>
<th>Conversion Factor</th>
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<tbody>
<tr>
<td>2018</td>
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<td>2019</td>
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<tr>
<td>2020</td>
<td>$36.0896</td>
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<tr>
<td>2021</td>
<td>$34.8931</td>
</tr>
<tr>
<td>2022 Pub.*</td>
<td>$33.5983</td>
</tr>
</tbody>
</table>
The 2022 Conversion Factor Journey: Important for Future Years

"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

<table>
<thead>
<tr>
<th>Year</th>
<th>Conversion Factor</th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>$36.0896</td>
</tr>
<tr>
<td>2021</td>
<td>$34.8931*</td>
</tr>
<tr>
<td>2022</td>
<td>$33.5983</td>
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</table>

*Congressional Action +3.75%

<table>
<thead>
<tr>
<th>TABLE 134: Calculation of the CY 2022 PFS Conversion Factor</th>
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<tbody>
<tr>
<td>CY 2021 Conversion Factor</td>
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<tr>
<td>Conversion Factor without CY 2021 Consolidated Appropriations Act Provision</td>
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<tr>
<td>Statutory Update Factor MACRA</td>
</tr>
<tr>
<td>CY 2022 RVU Budget Neutrality Adjustment</td>
</tr>
<tr>
<td>CY 2022 Conversion Factor</td>
</tr>
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</table>
The Voices Are Loud and Strong

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.

Deputy Leader Pelosi and Leader McCarthy,

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

The Honorable Kevin McCarthy
Majority Leader
U.S. House of Representatives
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.

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

Alina S. Adams, Ph.D.
Colin C. Alford
Mark E. Amode
Kelly Armstrong
Jake Auchincloss
Cynthia Axne
Brian Bacon, D.D.S.
Dan Bacon
Andy Barr
Gas M. Balazs
Sunford D. Bishop, Jr.
Lisa Blunt Rochester
Suzanne Bonamici
Mike Bost
Carolyn Bourdeaux
Brendan F. Boyle
Julia Brownley
Tim Burchett
Michael C. Burgess, M.D.
G. K. Butterfield
Sal Rubinfeld
Tom Caltagirone
Andrew Carson
Earl L. "Buddy" Carter
Markwayne M. Culbert
Ed Case
Kathy Castor
Liz Cheney
David N. Cicilline
Yvette D. Clarke
Emmanuel Cleaver, Jr.
Steve Cohen
Tim Cole
James Comer
Erin Cook
J. Luis Correa
Eric Costello
Angie Craig
Eric A. "Rick" Crawford
Don Crenshaw
Charlie Crist
Jason Crow
Henry Cueller
John Curtis
Shaneez L. Davis
Danny K. Davis
Rodney Davis
Mark DeSaulnier
Peter A. DeFazio
Anna Deligianni
Mark DeSaulnier
Ted Drews
Mike Doyle
Neil P. Dunn, M.D.
Tom Emmer
Ron Estes
Dwight Evans
Randy Feenstra
Brian Fitzpatrick
Charles E. "Chuck" Fleischmann
Lizzie Fitcher
Bill Foster
Scott Franklin
Ruben Gallego
John Garamendi
Andrew R. Garbarino
Mike Garcia
Bob Gibbs
Carlos A. Gimenez
Louie Gohmert
Jimmy Gomez
Anthony Gonzalez
Vince Gonzalez
Jennifer González-Colón
Lance Gooden
Josh Gottheimer
Sara Gru外界
Mark E. Green, M.D.
H. Morgan Griffith
Rand M. Grigorov
Glenn Grothman
Michael Guest
Jim Hagedorn
Josh Harder
Andy Harris, M.D.
Vicky Hartzler
Julianne Harrow
Julie Bennett
Brian Higgins
Clay Higgins
J. Freshour Hill
James A. Himes
Steven Horsford
Chris Houlahan
Richard Hudson
Ryan L. Jackson, M.D.
Chris Jacobs
Bill Johnson
Danny Johnson
Maulsby Jones
David P. Joyce
John Joyce, M.D.
Kanai Linakallu
Mickey Kaptur
John Katko
William R. Keating
Fred Keller
Mike Kelly
Robbie L. Kelly
Trent Kelly
David T. Kildee
Derek Kilmer
Young Kim
Ron Kind
Ann Kirkpatrick
Raja Krishnamoorthi
Ann M. Kuster
David Kustoff
Corder Lamb
Doug Lamborn
James L. Langevin
John B. Lambros
Robert E. Lance
Jake LaTurner
All Lawson, Jr.
Barbara Lee
David Loe
Teresa Leger Fernandez
Debbie Lesko
Mike Levin
Ted W. Long
Billy Long
Alex Lozano
Frank D. Lucas
Bruce Laukemper
Stephen F. Lynch
Tom Malinowski
Natalie Maudses
Carolyn B. Maloney
Treyice Mann
Kathy E. Massie
Brian Mast
Lacy Mauk
Betty McCollum
A. Donald McEachin
James P. McGovern
David B. McKinley
Grace Meng
Daniel Meser
eMarionette Miller-McCoy, M.D.
John R. Moolenaar
Larry Miller
Joseph D. Morelle
Seth Moulton
Frank P. Mojave
Machina Molinaro
Gregory F. Murphy, M.D.
Grace F. Napolitano
Joe Negron
Mario Noriega
Donald Norcross
Eleanor Holmes Norton
Tom O’Halleran
Diana Degette
Steven F. Palazzo
Jeremy Pacquet
Chris Pappas
Bill Pascrell, Jr.
• Protecting Medicare and American Farmers from Sequester Cuts Act
  – +3% (not 3.75%) increase to previously finalized CF- for one year
• 2022 Final CF: $34.6062
• Future Issues- Back to the SGR Days
  – 2% sequester – comes back in July 2022 and goes until 2031
  – 4% pay as you go – $1.9T American rescue Plan, OMB scorecard calculation pushed to 2023
  – Primary care complexity code -3% resurfaces 2024
  – Statutory Update from MACRA 2026 (based on 2024 performance)
    • +0.25% if you're in MIPS
    • +0.75% in you're in an APM
### 2022 CF Compared to 2021

<table>
<thead>
<tr>
<th>CY 2022 Quarter (Q)</th>
<th>PFS Conversion Factor (CF) Cut</th>
<th>Sequestration Cut</th>
<th>2022 vs. 2021 Total Cut</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q1 (Jan-Mar)</td>
<td>0.75%</td>
<td>0%</td>
<td>0.75%</td>
</tr>
<tr>
<td>Q2 (Apr-Jun)</td>
<td>0.75%</td>
<td>1%</td>
<td>1.75%</td>
</tr>
<tr>
<td>Q3 (Jul-Sep)</td>
<td>0.75%</td>
<td>2%</td>
<td>2.75%</td>
</tr>
<tr>
<td>Q4 (Oct-Dec)</td>
<td>0.75%</td>
<td>2%</td>
<td>2.75%</td>
</tr>
<tr>
<td>Year Average</td>
<td>0.75%</td>
<td>1.25%</td>
<td>2.00%</td>
</tr>
</tbody>
</table>
2022 Allowable by E/M Level

Sequester is AFTER the allowable
## Year Over Year Payment Comparison

<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>99283</td>
<td>1.84</td>
<td>$36.09</td>
<td>$66.60</td>
<td>2.09</td>
<td>$34.89</td>
<td>$72.93</td>
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<td>$34.61</td>
<td>$73.03</td>
<td>+$6.63</td>
<td>+10%</td>
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<tr>
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<td>$36.09</td>
<td>$121.98</td>
<td>3.55</td>
<td>$34.89</td>
<td>$123.87</td>
<td>3.56</td>
<td>$34.61</td>
<td>$123.21</td>
<td>+$1.23</td>
<td>+1%</td>
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<tr>
<td>99285</td>
<td><strong>4.91</strong></td>
<td>$36.09</td>
<td>$171.22</td>
<td><strong>5.18</strong></td>
<td>$34.89</td>
<td>$180.75</td>
<td><strong>5.17</strong></td>
<td>$34.61</td>
<td>$178.93</td>
<td>+$7.71</td>
<td>+5%</td>
</tr>
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</table>
CMS: “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
# 2022 Staged CPT E/M Changes

<table>
<thead>
<tr>
<th>Component(s) for Code Selection</th>
<th>Office or Other Outpatient Services</th>
<th>Other E/M Services (Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home, or Custodial Care, Home)</th>
</tr>
</thead>
<tbody>
<tr>
<td>History and Examination</td>
<td>As medically appropriate, Not used in code selection</td>
<td>Use key components (history, examination, MDM)</td>
</tr>
<tr>
<td>Medical Decision Making (MDM)</td>
<td>May use MDM or total time on the date of the encounter</td>
<td>Use key components (history, examination, MDM)</td>
</tr>
<tr>
<td>Time</td>
<td>May use MDM or total time on the date of the encounter</td>
<td>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.</td>
</tr>
<tr>
<td>MDM Elements</td>
<td>Number and complexity of problems addressed at the encounter</td>
<td>Number of diagnoses or management options</td>
</tr>
<tr>
<td></td>
<td>Amount and/or complexity of data to be reviewed and analyzed</td>
<td>Amount and/or complexity of data to be reviewed</td>
</tr>
<tr>
<td></td>
<td>Risk of complications and/or morbidity or mortality</td>
<td>Risk of complications and/or morbidity or mortality</td>
</tr>
</tbody>
</table>
2021/2022 Office Code Updated AMA/CPT Guidelines: MDM or Time Determines Office Code Choice

2021/2022 Office Visit Code Scoring

“The CPT code changes allow clinicians to choose the E/M visit level based on either medical decision making or time.”

CMS Physician Final Rule Press Release

1. Requires performance of history and exam only as medically appropriate

2. Allows clinicians to choose the E/M visit level:
   - Medical Decision Making; OR
   - Time (appendix)
Time noted NOT to apply in the ED

“Time is not a descriptive component for the **emergency department levels of E/M services** because emergency department services are typically provided on a variable intensity basis, often involving multiple encounters with several patients over an extended period of time.”

AMA - CPT 2021/2022 Professional Edition

Potentially Leaves the ED with MDM
2021/2022 Office/Urgent Care
- Hx and PE not scored
- MDM or Time
- Brand new MDM scoring grid
- 2021 changes now permanent

Emergency Department 2022
- 2022 no changes
- Hx and PE still required
- 1995 DGs continue: Hx, PE, MDM
- MDM not updated yet
- ACEP CPT RUC group targeting 2023 for updated ED guidelines

New MDM will be the main driver
Future ED Medical Decision Making

- Start preparation Summer of 2022

**Documentation Tips for the Future**

- Review of external notes (NH, EMS, DC Summary)
- Independent historian (parent, guardian, spouse)
- Independent interpretation of test
  - EKG, Rhythm strip, X-ray, CT
    - Especially if not billing
- Decision regarding hospitalization
- Testing considered if not performed (CT Scan)
- Treatment considered if not performed (Antibiotics)
“The final diagnosis for a condition does not in itself determine the complexity or risk, as extensive evaluation may be required to reach the conclusion that the signs or symptoms do not represent a highly morbid condition.”

AMA CPT 2021/2022
Silver Lining: Impetigo, my BP is elevated, but I came today because I twisted my ankle

“Multiple problems of a lower severity may, in the aggregate, create higher risk due to interaction.”

AMA CPT 2021/2022
Ordering a test may include those considered, but not selected after shared decision making.

For example, a patient may request diagnostic imaging that is not necessary for their condition and discussion of the lack of benefit may be required.

These considerations must be documented.
“Tests ordered are presumed to be analyzed when the results are reported. Therefore, when they are ordered during an encounter, they are counted in that encounter.”

AMA CPT 2021/2022
The Future of APP Shared Visits: Where and For What

“We believed that limiting the definition of shared visits to include only E/M visits in institutional settings, for which “incident to” payment is not available,... We did not see a need for split (or shared) visit billing in the office setting, because the “incident to” regulations govern situations where an NPP works with a physician who bills for the visit, rather than billing under the NPP’s own provider number.”

- Institutional setting only (e.g., Emergency Department, Obs unit…)
- E/M only- not procedures
“We also proposed to modify our policy to allow physicians and NPPs to bill for shared visits for both new and established patients, and for critical care and certain Skilled Nursing Facility /Nursing Facility (SNF/NF) E/M visits. We proposed these modifications to the current policy and conditions of payment to account for changes that have occurred in medical practice patterns, including the evolving role of NPPs as part of the medical team.”
Defining A Shared Visit: 2023 Clarity and 2022 Complex Transition Year

- 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 time, given the advent of EHRs.” (YIKES)
  - We are finalizing our definition of “substantive portion” as more than half of the total time spent by the physician and NPP beginning January 1, 2023.”

- “We understand that an adjustment period may be needed to establish systems to track time, especially since the coding for E/M visits in many facility settings will not use MDM or time to distinguish visit levels until 2023.”

2022 CMS Physician Fee Schedule Final Rule page 425/2414
“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.”

2022 CMS Physician Fee Schedule Final Rule page 425/2414
“It may be helpful for each practitioner providing the shared visit to directly document and time their activities in the medical record, to track and attribute time, in order to determine who performed the substantive portion. However, we believe we should leave it to the discretion of individual practitioners and the groups they work in to decide how time will be tracked.”

“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.”

Modifier –FS appended to the claim to identify shared services.
ACEP Question

“The final rule uses the term “substantive portion.” In keeping with CMS’ ongoing effort to reduce administrative burden and simplify documentation, would the physician, to bill under their NPI:

1. Simply document that “I provided a substantive portion of the care of this patient;”
2. Need to document which of the key elements they provided (Hx, PE, or MDM)
3. Need to document the detail of the key element they performed.

CMS Response

Signing and dating the MR and putting their name on the bill affirms that the individual performed the substantive portion, whatever they chose (for 2022, the only year they have a choice in what the substantive portion can be).

We did not finalize anything about identifying what they used as the substantive portion. Still, it would be good to encourage folks to talk to their local MAC to make sure the MAC doesn’t want them to identify what they used as the substantive portion.
“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.”

Physician Final Rule, pages 434 2022
Critical Care and 9928X
“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

But…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
Telehealth
COVID ED Telehealth Changes

- Expanded eligible telehealth services to include ED and Observation

  "We are adding the following codes to the existing list of telehealth services. CPT codes 99281-99285, 99217-99220, 99224-99226, 99234-99236."

  CMS-1744-IFC page 19/221

- ED Telehealth should use ED specific POS #23

  "We are instructing physicians and practitioners who bill for Medicare telehealth services to report the POS code that would have been reported had the service been furnished in person."

  CMS-1744-IFC page 15/221
COVID ED Telehealth Changes

- Telehealth paid at the same rate as in person services
  
  “The relative resource costs of services furnished through telehealth should be reflected in the payment as if they furnished the services in person.”
  
  CMS-1744-IFC page 14/221

- On site technology enabled visits are just regular visits
  
  “Services should only be reported as telehealth services when the individual physician or professional providing the telehealth service is not at the same location as the beneficiary.”
  
  CMS Telehealth FAQ #15
ED Telehealth Good News!

- ED and other key codes added to Category 3
- ED 99281-99285 (all codes not just 99281-99283)
- Critical care 99291-99292
- Subsequent observation (99224-99226) and Obs discharge

- Provider and patient in the same place = regular visit
• "We proposed to retain all services added to the Medicare telehealth services list on a Category 3 basis until the end of CY 2023.

• We noted that this proposal would allow us time to collect more information regarding utilization of these services during the pandemic, and provide stakeholders the opportunity to continue to develop support for the permanent addition of appropriate services to the telehealth list.”
Teaching physicians may meet the supervisory requirements using telehealth during the PHE.

“The requirement for the presence of a teaching physician can be met, through direct supervision by interactive telecommunications technology…the teaching physician must provide supervision either with physical presence or be present through interactive telecommunications technology during the key portion of the service.”

March 30th CMS IFR page 103/221
The Future of Teaching Physician Telehealth

- **Rural settings:** TP oversight via telehealth now permanent

  “We are finalizing a **permanent policy** to permit teaching physicians to meet the requirements to bill for their services involving residents through virtual presence... but only for services furnished in residency training sites that are located outside of an OMB-defined metropolitan statistical area (MSA).”  
  **CMS Physician Final Rule**

- **Non-rural settings:** Only during the PHE

  “We are not permanently finalizing our teaching physician virtual presence policies; however, they will remain in place for the duration of the PHE to provide flexibility for communities that may experience resurgences in COVID-19 infections.”  
  **CMS Physician Final Rule**
Telehealth Provider Documentation Process

- Document in the same manner as face-to-face
- HPI, Past/Family/Social Hx, ROS
- Visual Physical Exam
  - Some include vitals
- Medical Decision making such as differential including COVID concern, any prescriptions, testing or self monitoring instructions
During the Public Health Emergency 99281-99285 on the approved list as part of category 3 through 12.31.2023
- Need data and use cases to convert to permanent approval

PHE ends potentially 2022 calendar year
- Health Professional Shortage Area (HPSA) Congressional action
- Patient location of home require Congressional action

ACEP Task force advocating for ED telehealth has completed an extensive BOD research report
2023 – A Huge Year for ED Documentation Coding and Reimbursement

- 2023 very likely the ED codes will be scored by MDM
- 2023 very likely new MDM guidelines for ED
- 2023 updated ED RVUs – probably minimal change
- Conversion Factor issues continue into the future
- Telehealth remains in play until the end of 2023
Michael Granovsky MD CPC FACEP

www.logixhealth.com

mgranovsky@logixhealth.com

781.280.1575
Appendix: 2022 Facility Reimbursement Key Updates
Effective for dates of service
January 1, 2022

- New Code (249)
- Revised code (93)

- Contains new or revised text

- FDA approval pending

# Out of numerical sequence

★ Appendix P Telemedicine code

Code deleted Appendix B (63)
Reporting Fracture and/or Dislocation Treatment Codes

The physician or other qualified health care professional providing fracture/dislocation treatment should report the appropriate fracture/dislocation treatment codes for the service he or she provided. If the person providing the initial treatment will not be providing subsequent treatment, modifier 54 should be appended to the fracture/dislocation treatment codes. If treatment of a fracture as defined above is not performed, report an evaluation and management code.
“CMS has instructed hospitals to report facility resources for clinic and emergency department visits using CPT E/M codes and to develop internal hospital guidelines to determine what level of visit to report for each patient.” 2008 OPPS Final Rule

“In the absence of national visit guidelines, hospitals have the flexibility to determine whether or not to include separately payable services as a proxy to measure hospital resource use that is not associated with those separately payable services” 2008 OPPS Final Rule
1. The coding guidelines should reasonably relate the intensity of hospital resources to the different levels of effort represented by the code.
2. The coding guidelines should be based on hospital facility resources. The guidelines should not be based on physician resources.
3. The coding guidelines should be clear to facilitate accurate payments and be usable for compliance purposes and audits.
4. The coding guidelines should meet the HIPAA requirements.
5. The coding guidelines should only require documentation clinically necessary.
6. The coding guidelines should not facilitate upcoding or gaming.
7. The coding guidelines should be written.
8. The coding guidelines should be applied consistently across patients.
9. The coding guidelines should not change with great frequency.
10. The coding guidelines should be readily available for review.
11. The coding guidelines should result in coding decisions that could be verified by other hospital staff, as well as outside sources.
2022 No National ED Facility Guidelines

- 2022 CMS has demonstrated they are satisfied with the current ED Facility E/M process
- No anticipated changes to the reporting process
- For quite a few years CMS has simply stated they are continuing with current policies

"For 2022, we proposed to continue with our current clinic and emergency department (ED) hospital outpatient visits payment policies. For a description of the current clinic and hospital outpatient visits policies, we refer readers to the CY 2016 OPPS/ASC final rule with comment period (80 FR 70448)."

2022 OPPS Final Rule, page 550/1394

"We understand the interest in promulgating national guidelines but we continue to believe that it is unlikely that national guidelines could apply to the reporting of all ED visits."

2021 OPPS Final Rule, page 628/1312
### 2022 Facility ED E/M Level Reimbursement Stable

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2022 Facility Level Reimbursement

2022

$74.08
$134.15
$236.35
$371.52
$533.27
$760.74
2022 Trauma Activation

- Requires pre-hospital notification
- State or ACS trauma designation
- Medicare requires critical care
- No significant 2022 changes
- Specific code
  - HCPCS G0390
  - APC 5045 $972.94