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Compliance Today - November 2022

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Physician Fee Schedule 2023 proposal: Change is always constant

By Ronald Hirsch, MD, FACP, CHCQM, CHRI

No sooner did the August issue of *Compliance Today* with my article "Observing the regulatory nuances of observation services" start printing, the Centers for Medicare & Medicaid Services (CMS) released the 2023 Physician Fee Schedule (PFS) proposed rule, meaning a few of the issues discussed will soon be rendered obsolete.[1] As you may recall, in my article, I discussed the nuances of physician billing and the evaluation and management (E&M) codes for observation services delineated by CMS.[2] Those rules only allowed the physician who orders observation services to bill the initial observation service E&M codes, and those codes can only be used on the day the observation services are ordered. It was unclear why CMS set such stringent rules for professional fee billing of observation visits since the same rules do not apply to the ordering of inpatient admission, where the work product of the physician is the same, but asking "why" about most issues is usually futile.

Say goodbye to observation E&M codes

CMS is now proposing in the 2023 PFS rule to completely eliminate those observation E&M codes, 99217-99220, and 99234-99236, replacing them with the initial and subsequent inpatient hospital codes, CPT 99221-99223 and 99231-99239.[3] These codes will be retitled "Hospital Inpatient and Observation Care Services." Since there will no longer be any observation-specific visit codes, the confusion over who can bill observation visit codes and on which day, as discussed in my August article, will vanish.

In addition, CMS is proposing to adopt the 2023 code selection changes released by the American Medical Association (AMA).[4] These changes will also align hospital visit code selection with the office visit code selection changes made in 2021. It will base the code selection on the level of medical decision-making or total time—except for emergency department visits, which will be based solely on medical decision-making. This should come as welcome news to all, as the proliferation of copy-and-paste documentation templates has led to notes that do little to tell the story of why the patient is hospitalized; however, it allowed the physician to meet the documentation requirements for chosen visit level.

But that does not mean the physician can simply document their medical decision-making and assign a code. The AMA specifies, "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." While these elements are not required, it is hoped physicians will act in the best interests of their patients and document the information that other caregivers will need to properly care for their patients.

Let history be a lesson

While this proposal sparks a great deal of optimism, unfortunately, history may not be on our side with this change. In a completely unscientific survey amongst my LinkedIn connections who code or audit physician office visits, the vast majority stated that physicians continue to use the same visit templates that they used prior to the changes adopted in 2021 eliminating the requirement for a specific level of history and specific number of bullet points for each code. As one person stated, "80% of the providers I worked with didn't even know this change had happened. I educated them as part of teaching them about risk adjustment. They were over the moon once they understood it, and one of my colleagues famously had a provider say in his evaluation that he was able to see one more patient a day after we showed him what was required."[5]

Yet, even with this proposal to simplify E&M code selection, there may be problems. While the E&M code for an initial visit for a hospital patient will not vary if they are admitted as inpatient or are hospitalized as outpatient with observation services, the place of service must match the patient's admission status, using either 21-inpatient hospital or 22-outpatient hospital. While the Medicare physician fee schedule does not vary payment between those two sites of service, other payers have that ability; all payers can deny payment if the place of service codes for the facility and professional fees do not match.

Not inpatient and not observation?

In addition, when the AMA released the definitions for these new codes earlier this year, they left a loophole that, if nothing else, bothered me for years. As described in my article, there are patients who are hospitalized who are neither admitted as inpatient nor outpatients receiving observation services. Their status is outpatient, but they are hospitalized for outpatient surgery or other care that does not meet the definition of observation services. These patients receive medically necessary care from physicians—often in conjunction with the surgeon who performed an outpatient surgery—while the patient remains hospitalized. But because the patient is neither admitted as inpatient nor receiving observation services, the "Hospital Inpatient and Observation Care Services" codes do not apply to those visits.

In 2022 and prior years, physicians who performed such visits used "office and other outpatient" visit codes, 99201-99215, to code these visits. While the patient was an outpatient and these codes apply, the logic of the hospitalist who ordered observation using an observation visit code—choosing one of three levels—and the consultant using an office visit code—choosing one of five levels—never sat well with me. Yet, it appears that this confusion will persist into 2023 unless, of course, the AMA and CMS read my comments and act to correct this ambiguity prior to January 1.

More changes than can be described

CMS has also proposed to make changes to billing of prolonged visits, establishing Medicare-specific codes—which will undoubtedly lead to confusion—but has proposed to delay their changes to split/shared visits that were to take effect in 2023. This should bring a sigh of relief, albeit temporary, to the many physicians who work collaboratively with nonphysician practitioners. There is much more in the 2,066 pages, including topics as varied as changes to shared savings programs, single-dose medications billing to specific dental services coverage, and colonoscopy coding. As noted, the final rule will be released around November 1, giving you about two months to work with your health information management and coding teams to ensure your doctors are ready on January 1, 2023, to comply with the new rules.

Takeaways

- The codes for observation services will sunset January 1, 2023, and providers will use the inpatient service

code set for all inpatient and observation encounters.

- Although the codes will not vary, it is important to ensure the place of service code matches the patient's registered status as inpatient or outpatient.
- The documentation requirements for hospital visits will change, no longer requiring a specific number of history or review of services elements.
- Visit levels will be chosen based on medical decision-making or time for all visits except emergency department visits which will be based on medical decision-making only.
- The final rule should be released on or around November 1, so all readers should review the final rule to assess for any changes from the proposals discussed here.

1 Ronald Hirsch, "Observing the regulatory nuances of observation services," *Compliance Today*, August 2022, https://bit.ly/3RBfE3n.
2 Centers for Medicare & Medicaid Services, "Chapter 4 – Part B Hospital (Including Inpatient Hospital Part B and OPPS)," *Medicare Claims Processing Manual,* Pub. 100-04, revised June 15, 2022, https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/clm104c04.pdf
3 Centers for Medicare & Medicaid Services, "Medicare and Medicaid Programs: Calendar Year 2023 Payment Policies under the Physician Fee Schedule and Other Changes to Part B Payment Policies, Medicare Shared Savings Program Requirements, etc.," July 28, 2022, https://www.regulations.gov/document/CMS-2022-0113-1871.
4 American Medical Association, "CPT® Evaluation and Management (E/M) Code and Guideline Changes," 2002, https://www.ama-assn.org/system/files/2023-e-m-descriptors-guidelines.pdf.
5 Ronald Hirsch, "Physician office visit coders – question for you," LinkedIn post, July 2022, https://bit.ly/3eKYO3L.