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Sophie Lee (sophie.lee@fticonslting.com) is Director at FTI Consulting, Atlanta, GA.

CY 2023 Medicare Physician Fee Schedule changes that compliance officers should observe

by Sophie Lee

One of the many challenges for a compliance professional is staying abreast of constantly changing rules, regulations, and guidelines. Every year, the Centers for Medicare and Medicaid Services (CMS) issues a midyear proposed rule specifying policy changes for Medicare payments under the Physician Fee Schedule. After a notice and comment period, a final rule is published in November, effective in the upcoming calendar year. CMS published its calendar year (CY) 2023 Medicare Physician Fee Schedule (MPFS) final rule on November 1. Although many of its key provisions, such as payment rate changes and conversion factor updates, may not directly impact compliance officers' activities, a few final rule updates require compliance officers' attention for CY 2023.

This article discusses CY 2023 MPFS final rule changes to evaluation and management services (E/M), split (i.e., shared) services, telehealth, and behavioral health services.

Evaluation and management services

For more than three decades, the billing of evaluation and management services (E/M) for physicians and qualified healthcare practitioners was determined by three key components—history, physical examination, and medical decision-making—documented in the medical records.[1] As part of the ongoing efforts by CMS to reduce the administrative burden for healthcare providers, significant changes in E/M coding and documentation guidelines for office and outpatient visits emerged in 2021; the history and physical examination no longer determined the selection of an E/M service code. Instead, the E/M code selection depended on either the level of medical decision-making or the time needed to perform the services on the day of the encounter.[2]

For CY 2023, the changes in coding and documentation applied to office and outpatient E/M visits will be adapted to other types of E/M visits, including hospital inpatient/observation, emergency department (ED), nursing facility, home or residence services, and cognitive impairment assessment. These changes allow providers to use total time or medical decision-making for selecting the E/M visit level; history and physical examination would no longer be used.[3] The definition of total time and medical decision-making differs from the pre-2021 guidelines. Note that time is not a descriptive component for the ED levels of E/M service because ED services are typically provided on a variable-intensity basis, often involving multiple encounters with several patients over an extended period.[4]

Although the guidelines seek to reduce documentation burden, the CY 2023 changes may pose challenges to providers. The documentation for medical decision-making can be difficult as the provider's thought process is

quantified in deciding the correct level of E/M service.[5] The 2021/2023 guidance has a strict framework of definitions that guide the coding process.Moreover, if providers choose to use total time as the basis of the selection of E/M code, be aware of the inclusions and exclusions.Compliance officers may want to consider collaborating with providers and/or operation teams to develop internal guidance or job aids and perform periodic audits to ensure billing compliance.