HSG advisors

2023 Medicare Physician Fee Schedule

2023 Medicare Physician Fee Schedule Final Rule

- Background
- E/M Coding Documentation Changes
- E/M Coding Changes
- Split/Shared E/M Visits
- Telehealth

Presenter

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EXPERTISE

- Family Physician and Former Health System CMO
- Physician Leadership and Governance
- Vision Development
- Compensation Planning

2023 MPFS Background Information

Medicare Physician Fee Schedule (MPFS)

- Since 1992, the MPFS has determined **professional service reimbursement requirements and rates**
  - Applies to payment for services provided by physicians and other practitioners at all sites of service
- Includes many other CMS regulatory changes related to physician practice
- Proposed Rule usually released mid to end of July
  - Published in Federal Register thereafter
  - 2023 Proposed Rule was released July 7th
- Public comment period follows – 60 days
  - CMS considers, and responds; may or may not impact Final Rule
- **Final Rule is usually released on or about November 1st**
  - Published in Federal Register thereafter
  - 2023 Final Rule released November 1st
- Many elements effective "immediately" on the following January 1st
  - Some are projected out 1-2 or more years before the effective date
  - … and may change from one Final Rule to the next

Overview of Major Elements

- Conversion Factor decreased
- E/M Coding Documentation Changes
- E/M Code Changes
- Split/Shared Visits Change Delay
- Telehealth Services and the PHE
- Behavioral Health Services Changes
- Chronic Pain Management Changes
- Audiology Services
- RHCs and FQHCs

2023 MPFS Conversion Factor

- Final Rule projected a 4.5% decrease in the Medicare Conversion Factor
  - 3% due to the expiration of the supplemental Congressional funding for 2022
  - 1.5% due to the E/M coding changes
- For the 3rd year in a row, Congress responded to public calls for support
  - Consolidated Appropriations Act of 2023
    - Signed into law on December 29, 2022
    - Added funding to allay 2.5% of the conversion factor reduction for 2023 for a net reduction of 2%
      - Also funded a 1.25% positive adjustment for 2024 – a departure from the annual adjustments of the previous two years
    - Also delayed implementation of the 4% PAYGO deduction for two years
    - Continued the Advanced APM arm of MACRA an additional year but at 3.5% rather than the original 5%
    - Extended telehealth waivers (see below)

2023 E/M Coding Documentation Changes

2023 E/M Coding Documentation Changes

- Designed to decrease the administrative burden of the encounter coding process
- Effective January 1, 2023
- Applied the office-based coding documentation changes promulgated in the 2021 Medicare Physician Fee Schedule to "Other E/M visits"
    - Hospital inpatient and observation status patient encounters
    - Emergency Department patient encounters
    - Nursing Facility patient encounters
    - Home/residence services patient encounters
    - Cognitive Impairment Assessments
- Creates a unified set of coding documentation rules for office, hospital, and nursing home encounters

2023 E/M Coding Documentation Changes

- Determine coding level by either a modified medical decision-making (MDM) approach or a total time dedicated (Time) approach
    - Note that only the modified medical decision-making approach applies to Emergency Department encounters and Cognitive Impairment Assessments
    - Note that only the total time dedicated applies to hospital discharge visits
- Encounter documentation includes a “medically appropriate” history and physical examination, but the history and exam does not determine the coding level

2023 E/M Coding Documentation Changes

- Total dedicated time methodology
  - Include all personally dedicated time spent caring for patient before, during, and after the face-to-face encounter(s) on day of service
    - Time dedicated to patient admission that extends beyond midnight can be included in the day of admission time frame
    - Does not include travel time, teaching time, or time spent performing separately billable procedures
  - A summary slide follows

2023 E/M Coding Documentation Changes

Total Dedicated Time Summary Table

Encounter Type	Straightforward Level Visit	Low-Level Visit	Moderate-Level Visit	High-Level Visit
Office (Established)	99212: 10-19 min	99213: 20-29 min	99214: 30-39 min	99215: 40-54 min
Office (new)	99202: 15-29 min	99203: 30-44 min	99204: 45-59 min	99205: 60-74 min
Hospital (initial, i.e., admits)		99221: 40 min or more	99222: 55 min or more	99223: 75 min or more
Hospital (admit/discharge same day)		99234: 45 min or more	99235: 70 min or more	99236: 85 min or more
Hospital (subsequent)		99231: 25 min or more	99232: 35 min or more	99233: 50 min or more
Hospital (discharge)		99238: 30 min or less	99239: 31 min or more	
Nursing home (initial)		99304: 25 min or more	99305: 35 min or more	99306: 45 min or more
Nursing home (subsequent)	99307: 10-14 min	99308: 15 min or more	99309: 30 min or more	99310: 45 min or more

Adapted from K. Millette, MD, "The 2023 Hospital and Nursing Home E/M Visit Coding Changes." FPM, January/February 2023.

2023 E/M Coding Documentation Changes

- Medical Decision-Making methodology
  - Four (4) levels of medical decision-making – straightforward, low, moderate, and high – based on three (3) factors – number and complexity of problems addressed, amount and complexity of data reviewed/considered, and patient risk of complications/morbidity/mortality
    - Level of E/M service selected is that satisfied by at least 2 of the 3 elements (problem, data, risk)
    - Similar to the office-based requirements
      - Level 1 initial or subsequent hospital visit criteria = level 3 office visit
      - Level 2 initial or subsequent hospital visit criteria = level 4 office visit
      - Level 3 initial or subsequent hospital visit criteria = level 5 office visit
    - Highest level of care applies for any of the following situations:
      - Escalating care (e.g., transfer to ICU)
      - Deescalating care or discussing DNR status due to poor prognosis
      - Initiating medications that require intensive monitoring
      - Deciding on emergency surgery regardless of patient risk factors

2023 E/M Coding Documentation Changes

Medical Decision-Making methodology – **Problems**

CPT Code	Level of MDM	Number/complexity of Problems Addressed
99202, 99212,99221, 99231, 99234, 99242, 99252	Straightforward	1 self-limited or minor problem
99203, 99213, 99221, 99231, 99234, 99243, 99253	Low	❑ 2 or more self-limited or minor problems **OR** ❑ 1 stable chronic illness **OR** ❑ 1 acute, uncomplicated illness or injury **OR** ❑ 1 stable acute illness **OR** ❑ 1 acute, uncomplicated illness or injury requiring hospital inpatient or observation level of care
99204, 99214, 99222, 99232, 99235, 99244, 99254	Moderate	❑ 1 or more chronic illnesses with exacerbation, progression, or side effects of treatment; **OR** ❑ 2 or more stable chronic illnesses; **OR** ❑ 1 undiagnosed new problem with uncertain prognosis; **OR** ❑ 1 acute illness with systemic symptoms; **OR** ❑ 1 acute complicated injury
99205, 99215, 99223, 99233, 99236, 99245, 99255	High	❑ 1 or more chronic illnesses with severe exacerbation, progression, or side effects of treatment; **OR** ❑ 1 acute or chronic illness or injury that poses a threat to life or bodily function

Adapted from American Society of Clinical Oncology "2023 Evaluation and Management Changes: Medical Decision-Making Simplified"

2023 E/M Coding Documentation Changes

Medical Decision-Making methodology – **Data**

CPT Code	Level of MDM	Amount and/or Complexity of Data to Be Reviewed and Analyzed
99202, 99212,99221, 99231, 99234	Straightforward	Minimal or none
99203, 99213, 99221, 99231, 99234	Low	Low (Must meet at least 1 of 2 categories) ❑ Category 1: Tests and documents … At least 2 of the following: ▪ Review of prior external note(s) from each unique source ▪ Review of the result(s) of each unique test ▪ Ordering of each unique test --- **OR** --- ❑ Category 2: Assessment requiring an independent historian(s)
99204, 99214, 99222, 99232, 99235	Moderate	Moderate (Must meet at least 1 out of 3 categories) ❑ Category 1: Tests, documents, or independent historian(s) … Any combination of any 3 of the following: ▪ Review of prior external note(s) from each unique source ▪ Review of the result(s) of each unique test ▪ Ordering of each unique test ▪ Assessment requiring an independent historian(s) --- **OR** --- ❑ Category 2: Independent interpretation of tests ▪ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) --- **OR** --- ❑ Category 3: Discussion of management or test interpretation ▪ Discussion of management or test interpretation with external physician/other qualified health care professional/appropriate source (not separately reported)

2023 E/M Coding Documentation Changes

Medical Decision-Making methodology – **Data** (continued)

CPT Code	Level of MDM	Amount and/or Complexity of Data to Be Reviewed and Analyzed
99205, 99215, 99223, 99233, 99236	High	High (Must meet at least 2 out of 3 categories) ❑ Category 1: Tests, documents, or independent historian(s) … Any combination of 3 of the following: ▪ Review of the result(s) of each unique test ▪ Ordering of each unique test ▪ Ordering of each unique test ▪ Assessment requiring an independent historian(s) --- **OR** --- ❑ Category 2: Independent interpretation of tests ▪ Independent interpretation of a test performed by another physician/other qualified health care professional (not separately reported) --- **OR** --- ❑ Category 3: Discussion of management or test interpretation ▪ Discussion of management or test interpretation with external physician/other health care professional/appropriate source (not separated reported)

2023 E/M Coding Documentation Changes

Medical Decision-Making methodology -- **Risk**

CPT Code	Level of MDM	Risk of Complications and/or Morbidity or Mortality of Patient Management
99202, 99212,99221, 99231, 99234	Straightforward	❑ Minimal risk of morbidity from additional diagnostic testing or treatment
99203, 99213, 99221, 99231, 99234	Low	❑ Low risk of morbidity from additional diagnostic testing or treatment
99204, 99214, 99222, 99232, 99235	Moderate	❑ Moderate risk of morbidity from additional diagnostic testing or treatment Examples: ▪ Prescription drug management ▪ Decision regarding minor surgery with identified risk factors ▪ Decision regarding elective major surgery without identified risk factors ▪ Social determinants of health affecting diagnosis or treatment
99205, 99215, 99223, 99233, 99236	High	❑ High risk of morbidity from additional diagnostic testing or treatment Examples: ▪ Drug therapy requiring intensive monitoring for toxicity ▪ Decision regarding major elective surgery with identified risk factors ▪ Decision regarding emergency major surgery ▪ Decision regarding hospitalization or escalation of hospital-level care ▪ Decision not to resuscitate or de-escalate care due to poor prognosis ▪ Parenteral controlled substances

2023 E/M Coding Documentation Changes

- **Compensation Impact**
  - Depends on the impact on historic individual coding curves and whether continue to use MDM or use total time spent
  - Predominant opinion is that the 2023 coding documentation changes will not have a significant impact on most providers if use MDM but may increase levels if use time spent (CMS opinion)
  - Greater impact may be with alterations of the clinical documentation templates in the EMR - whose construction depended on the 1995/1997 coding documentation criteria and are heavily weighted toward counting systems reviewed and examined
  - As in the office setting, utilizing total time criteria will require adequate documentation of time spent on various activities on the day of service – a requirement for which many providers are not accustomed
  - As in the office setting, utilizing MDM criteria may require better documentation of thought processes and all items considered in the decision-making process – which historic clinical documentation templates do not support well

2023 E/M Coding Changes

2023 MPFS E/M Coding Changes

- Designed to decrease the administrative burden of the encounter coding process
- Effective January 1, 2023
- Inpatient and Observation Care Services
  - Deleted Observation Status codes 99217-99220 and 99224-99226
    - Merged the care into existing hospital care CPT codes
      - 99221-99223 – Initial inpatient or observation care per calendar day … 40, 55, and 75 minutes must be met or exceeded
      - 99231-99233 – Subsequent inpatient or observation care per calendar day … 25, 35, and 50 minutes must be met or exceeded
      - 99238-99239 – Hospital discharge day management … ≤ 30 minutes or greater than 30 minutes
    - Conversion from Observation to Inpatient continues the services interval (subsequent care for inpatient when involved in Observation care v. new initial care) so the change makes this claims process more seamless
    - Retained CPT codes 99234-99236 … Admission and Discharge on same day – either inpatient or observation – for which 45, 70, and 85 minutes must be met or exceeded
      - Retained 8 to 24-hour Rule

2023 MPFS E/M Coding Changes

Inpatient and Observation Care Services

- Summary of 8 to 24-hour Rule

Hospital Length of Stay	Discharged On	Code(s) to Bill
< 8 hours	Same calendar date as admission or start of observation	Initial hospital services only*
8 or more hours	Same calendar date as admission or start of observation	Same-day admission/discharge*
< 8 hours	Different calendar date than admission or start of observation	Initial hospital services only*
8 or more hours	Different calendar date than admission or start of observation	Initial hospital services* + discharge day management

* Plus prolonged inpatient/observation services, if applicable.

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2023 MPFS E/M Coding Changes

- Inpatient and Observation Care Services
  - Modified the definitions of initial and subsequent care
    - Initial – when the patient has not received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty ***who belongs to the same group practice*** during the stay
    - Subsequent – when the patient has received any professional services from the physician or other qualified health care professional or another physician or other qualified health care professional of the same specialty ***who belongs to the same group practice*** during the stay.
    - May allow for greater wRVU accrual in instances of cross coverage by different groups of the same specialty during an inpatient or observation patient stay.
      - Member of different group of same specialty seeing patient for 1st time seemingly can bill initial rather than subsequent care
    - **Note** that CMS still considers APPs to be a different specialty than the physician specialist they work with
      - Re-iterated in the Final Rule

2023 MPFS E/M Coding Changes

Inpatient and Observation Care Services

- wRVU and Compensation Impact – Slight increases with 2023 coding re-evaluation

Observation Codes	wRVU Values	Consolidated Codes	wRVU Values
99218	1.92	99221	1.63
99219	2.60	99222	2.60
99220	3.56	99223	3.50
99224	0.76	99231	1.00
99225	1.39	99232	1.59
99226	2.00	99233	2.40
99217	1.28	99238	1.50

- Cross coverage by different group impact – marginal as a one-time per episode 0.53 wRVU difference

2023 MPFS E/M Coding Changes

- Consultation Services
  - Deleted lowest level office (99241) and inpatient (99251) consultation codes
    - Aligns with four levels of medical decision-making (Office 99242-99245) (Inpatient/Observation 99252-99255)
    - Consistent with the elimination of the office E/M code 99201 in 2021 (New Patient 99202-99205)
    - Negligible compensation impact
  - Note that CMS re-iterated that it does not pay for consultation codes
- Emergency Department Services
  - Designated the lowest level code (99281) to describe visits that do not require a physician/APP
    - Similar to office code 99211
    - Negligible compensation impact
- Suture and Staple Removal
  - Added two add on codes for E/M codes for suture and/or staple removal – regardless of who placed them
    - +15853 = Removing *either* sutures or staples without anesthesia
    - +15854 = Removing *both* sutures and staples without anesthesia
    - Both have revenue but zero wRVU value – and, therefore, no impact on compensation

2023 MPFS E/M Coding Changes

- Chronic Pain Management Services
  - Created new HCPCS codes for monthly bundled chronic pain management services
    - G3002 – Required initial face-to-face visit of at least 30 minutes by physician or APP … or … first 30 minutes of CPM care provided by physician or APP per calendar month
    - G3003 – Each additional 15 minutes of CPM by physician or APP per calendar month
  - Bundled services include
    - Diagnosis, assessment and monitoring
    - Development, implementation, revision/maintenance of person-centered care plan
      - Includes strengths, goals, clinical needs, desired outcomes
    - Overall treatment management – including medication management
    - Pain and health literacy counseling
    - Crisis management
    - Care coordination
  - RHCs and FQHCs would capture under G0511 code

Code	Revenue	wRVU Value
G3002	$80.99	1.45
G3003	$29.48	0.50

2023 MPFS E/M Coding Changes

Nursing Facility Services

- Deleted code 99318 (annual nursing facility assessment)
  - Report through the subsequent care codes (99307-99310) – marginal impact

Deleted Code	Duration	wRVU Value	Code Options	Duration	wRVU Value
99318	30 minutes	1.71	99307	10 minutes	0.76
			99308	15 minutes	1.16
			99309	25 minutes	1.55
			99310	35 minutes	2.35

- Adopted the same definitions for initial and subsequent as for inpatient/observation – same specialty in same group
  - May have marginal impact on compensation in cross coverage situations (initial v. subsequent care the 1st time involved)

2023 MPFS E/M Coding Changes

Nursing Facility Services

- Revised wRVU values for codes 99304-99310 … and some of the time spent requirements

CPT Code	2022 Duration	2022 wRVU Value	2023 Duration	2023 wRVU Value
99304	25 minutes	1.64	25 minutes	1.50
99305	35 minutes	2.35	35 minutes	2.50
99306	45 minutes	3.06	45 minutes	3.50
99307	10 minutes	0.76	10 minutes	0.70
99308	15 minutes	1.16	15 minutes	1.30
99309	25 minutes	1.55	**30 minutes**	1.92
99310	35 minutes	2.35	**45 minutes**	2.80
99315	≤ 30 minutes	1.28	≤ 30 minutes	1.50
99316	> 30 minutes	1.90	> 30 minutes	2.50

- May experience an increase in wRVUs earned and resulting compensation

2023 MPFS E/M Coding Changes

Home and Residence Services

- Deleted domiciliary or rest home codes (New Patient 99324-99328; Established Patient 99334-99337) [Deleted 99339, 99340]
  - Merged with existing home visit codes 99341-99350 (New patient 99341-99345; Established patient 99347-99350) … and deleted 99343 as duplicate medical decision-making criteria

Deleted Code	Duration	wRVU Value	Code Options	Duration	wRVU Value
99324	20 minutes	1.01	99341	20 minutes	1.00
99325	30 minutes	1.52	99342	30 minutes	1.65
99326	45 minutes	2.63	~~99343~~	~~45 minutes~~	~~2.53~~
99327	60 minutes	3.46	99344	60 minutes	2.87
99328	75 minutes	4.09	99345	75 minutes	3.88
99334	15 minutes	1.07	99347	15 minutes	0.90
99335	25 minutes	1.72	99348	25 minutes	1.50
99336	40 minutes	2.46	99349	40 minutes	2.44
99337	60 minutes	3.58	99350	60 minutes	3.60

Potential marginal decreases

2023 MPFS E/M Coding Changes

- Prolonged Services
  - CMS and AMA CPT differ in approach
    - CMS – Use requires exceeding the *maximum* time interval of the longest base code by 15 minutes to use the code
      - Use for every completed 15-minute increment starting 15 minutes after the longest base code interval
        - If highest code is 75 minutes in duration, the application of the prolonged services code starts at 90 minutes and can be billed when reach 105 minutes
    - AMA CPT – Use requires exceeding the *minimum* time interval of the base code by 15 minutes to use the code
  - CMS Prolonged Services Codes
    - G0316 – prolonged services for inpatient and observation care services
      - Not applicable to hospital discharge services as the longer 99239 code applies
    - G0317 – prolonged services for nursing facility services
    - G0318 – prolonged services for home residence services
    - G2212 – prolonged services for office or other outpatient services

2023 Spilt/Shared Visit Changes

2023 Spilt/Shared Visit Changes

- The Final Rule extended the deadline to move to "time spent" as the sole criterion for determining the billing provider for Split/Shared Visits until 2024 (from January 1, 2023)
- The 2022 Medicare Physician Fee Schedule Final Rule delineated the following changes effective January 1, 2022:
    - **Definition.** An E/M visit in a facility setting that is performed in part by a physician and an APP who are in the same group.
        - Clarified that applies to Hospital, SNF locations of care
        - "Incident to" billing applies to office situations
    - **Applicable Encounters.**
        - Newly applied to new and established patients; initial and subsequent visits; critical care services; and prolonged services
        - Previously only applied to established patients

2023 Spilt/Shared Visit Changes

- The 2022 Medicare Physician Fee Schedule Final Rule delineated the following changes:
  - **Billing Provider Determination.**
    - The 2022 Medicare Physician Fee Schedule Proposed Rule advocated that the billing provider be determined by the individual who dedicated more than half of the total time spent on the day of service
      - Time spent criteria the same as for office-based – and now inpatient – total time determination
    - Based on public comment, the 2022 Final Rule allowed the billing provider to be determined as either the individual who spent more than half of the total time dedicated to the patient encounter on the date of service – or the individual that provided the entirety of H&P/assessment or medical decision making that the billing level required (except for critical care, which is solely time-based)
      - Tended to allow physicians be the billing provider with full reimbursement rates by indicating the physician provided 100% of the medical decision-making for the interaction(s)
    - The 2022 Final Rule also indicated that time spent would be only criterion starting in 2023
    - The 2023 Medicare Physician Fee Schedule Final Rule continued the 2022 contingencies and projected that time spent would be the only criterion starting in 2024

2023 Spilt/Shared Visit Changes

- The 2022 Medicare Physician Fee Schedule Final Rule also delineated the following changes:
  - **Documentation Requirements.** The billing provider must …
    - Sign and date the encounter document
    - Clearly indicate the physician and APP involved in the patient's care and their roles in that care
    - Include the individual time and/or effort dedicated to the encounter in sufficient detail to justify the "Billing Provider" determination
  - **Claims Submission.**
    - E/M must be annotated by a specific modifier (FS) regardless of the provider type under which the encounter is billed
      - Permits identification and tracking of these encounters
      - Was not able to be done in the past without performing random manual record reviews
      - CMS stated modifier is important for ensuring program integrity
      - Interpreted to imply that these claims can now actually be tracked and audited
    - Previously identified these encounters through internal designations – if at all
      - Billing Provider = Physician; Rendering Provider = APP
      - Internal modifier that was not reported externally

2023 Spilt/Shared Visit Changes

- Be ready for 2024 – and ensure currently compliant with 2022 changes
- **Compensation Impact**
    - Workload Attribution/Production-Based Provider Compensation
        - Many organizations directly attribute wRVUs generated by Split/Shared Visits to the "Billing Provider"
        - Historically, the "Billing Provider" was generally the physician which allowed full reimbursement for the professional services rendered by the care team
        - If APP becomes the designated "Billing Provider" by performing the "substantive portion" of the encounter based on total time spent in 2024, the APP would be awarded all wRVU credit for these encounters
            - Most physician/APP care delivery models involve the APP spending significant time on each encounter so that the physician time spent is minimal and efficient – and allows the physician to move on to other encounters
        - … and the involved physicians' wRVU credit would plummet

2023 Spilt/Shared Visit Changes

- **Compensation Impact** (continued)
  - Consider implementing one of the following prior to 2024
    - Create team-based productivity incentive that pools earned wRVUs and distributes them equally among the involved physicians and APPs according to service or participation FTE … **OR** …
    - Create mechanism to distribute wRVUs associated with Split/Shared Visits among the contributing individuals for each encounter
      - 50/50 distribution promotes team-centered approach
      - Requires the ability to identify the individuals involved in each patient's care and determine a fair distribution methodology … **OR** …
    - Eliminate productivity component for shift-based providers, such as hospitalists, CCM
      - Incentivize covering additional shifts to augment base compensation
      - Incentivize nonproductivity elements like hospital clinical quality metric performance, committee participation, discharge summary completion, and others

2023 Spilt/Shared Visit Changes

- **Reimbursement/Revenue Impact**
  - Since most organizations previously designated the physician as the "Billing Provider," received 100% of anticipated professional services revenue for the encounters
    - Compared to an APP as the "Billing Provider," which decreases revenue generation to 85% of the fee schedule amount for the services
  - Most organizations would anticipate a significant shift in "Billing Provider" designation to APPs under the 2024 "time spent" designation
    - The APP model historically entails the APP spending the majority of time each day dedicated to these patient encounters so that the physician time is used most efficiently – and spends less time with each patient than the APP spends
    - If this care delivery model holds true, organizations will receive 15% less revenue for the same volume and types of rendered professional services for many specialties

2023 Spilt/Shared Visit Changes

- **Compliance Impact**
  - CMS' new requirement for adding a defined modifier to claims submitted for these visits allows them to be targeted for CMS audits
  - Recommend internal audit process to ensure that the required documentation and billing parameters are routinely followed

Telehealth

Telehealth

- The combination of the 2023 MPFS, the Consolidated Appropriations Act, 2023 and the previous Consolidated Appropriations Act, 2022 extended the COVID PHE waivers for 151 days beyond the end of the PHE – or the end of the calendar year … whichever is greater
- The PHS has been extended into April 2023 – which many feel will be the last extension
- The following waivers are likely to continue through December 31, 2023
    - The ability to see a patient in their own home regardless of geographic location
    - The expanded list of eligible providers (like PT, OT, speech)
    - The ability for RHCs and FQHCs to be distant site providers
    - The ability to provide audio-only encounters
    - The continued delay of the initial in-person visit requirement for mental health encounters
    - The continued reimbursement of telehealth encounters at in-person rates
    - The ability to waive Medicare co-pays for virtual communications (Virtual Check-ins, eVisits)

HSG advisors | Questions

HSG Core Offerings

HSG Advisors (HSG) partners with health systems to transform their approach to their markets, services, and providers for improved growth and operational and financial sustainability.

Headquarters: Louisville, KY
Formed: 1999

HSG CLAIMS DATA ANALYTICS

Evaluate competitive dynamics within markets, service lines, providers and patients based on all-player healthcare claims data analysis and HSG insights and expertise.

HSG STRATEGY

Define strategic goals and direction for your health systems' long-term growth plans that allows for the simultaneous pursuit of immediate market opportunities, focused on growth strategies and Medical Staff Development Planning.

HSG EMPLOYED PROVIDER NETWORKS

Improve your financial and quality performance and overall Operational Excellence by building a Shared Vision and developing strong organizational, leadership, and governance support structures.

HSG COMPENSATION AND COMPLIANCE

Develop sustainable provider compensation solutions to achieve market competitiveness, financial sustainability, and regulatory compliance through compensation model development and implementation.

HSG Services

HSG builds high-performing physician networks so health systems can address complex changes with confidence.

HSG CLAIMS DATA ANALYTICS

- HSG Outpatient and Physician Office Market Share™
- HSG Patient Share of Care™
- HSG Patient Flow™

HSG STRATEGY

- Market Share Growth Strategy
- Medical Staff Development Planning
- Health System Strategic Planning

HSG EMPLOYED PROVIDER NETWORKS

- Operational and Financial Performance Improvement
- Network & Practice Turnaround
- Infrastructure and Leadership Growth

HSG COMPENSATION AND COMPLIANCE

- Compensation Plan Design
- Fair Market Valuation Services
- Hospital-based Subsidy Arrangements

HSG advisors | Thank You