ARTICLE

HSG COMPENSATION AND COMPLIANCE

HSG's 2023 Provider Compensation Survey: Time Dedication during Visits and it's Effect on Compensation

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It has been more than 18 months since CMS "clarified" the circumstances surrounding split/shared visits with the release of the 2022 Medicare Physician Fee Schedule (MPFS) Final Rule. Yet many organizations have either not grasped or chosen to grapple with the potential ramifications. These impressions led us to survey organizations regarding the changes in January 2023. The survey results validated our impressions. **Click here** to access the entire survey with results.

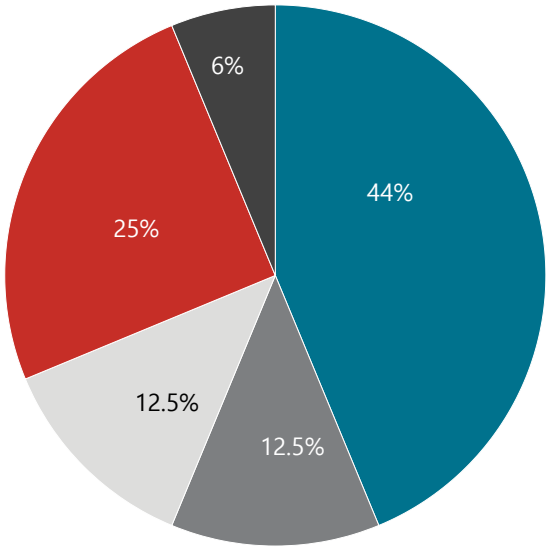
SPLIT/SHARED VISITS – MAJOR ISSUES LOOM

One of the January 2023 HSG Provider Compensation Survey questions asked "In 2024, we will see a transition to total dedicated time spent during split billing/shared visits. Do you anticipate this change will impact your providers' compensation?" Of the respondents, **44%** indicated that they are **"Not sure as we have not yet analyzed the potential impact."** An additional **25%** of respondents indicated that they believe the changes **will impact provider compensation, "but we are not prepared to address the Work RVU ("wRVU") impact."** Of the remaining respondents, **7% indicated that they are prepared for the impact, 14% felt that the impact would be marginal (and presumably not an issue to be concerned about), and nearly 11% indicated that they were changing their care delivery model to avoid a negative impact on physicians.**

FIGURE 1

Question 7 from our 2023 Provider Compensation Audience Survey

In 2024, we will see a transition to total dedicated time spent during split billing/shared visits. Do you anticipate this change will impact your providers' compensation?



- Yes – we are prepared for the wRVU impact (6%)
- Yes – but we are not prepared to address the wRVU impact (25%)
- No – the APP involvement in these visits is marginal (12.5%)
- No – we are altering our care delivery model to avoid a negative impact on physician wRVUs (12.5%)
- Not sure – we have not yet analyzed the potential impact (44%)

SO, WHAT MAKES THE SPLIT/SHARED VISIT RULE CHANGES AN ISSUE FROM THE PROVIDER COMPENSATION PERSPECTIVE?

The bottom line depends on how organizations attribute wRVU workload credit between the physicians and APPs involved in these patient encounters, and if those physicians and/or APPs are compensated based on personally performed wRVU production. Establishing a common frame of reference is important to allow us to explore potential issues more fully.

CMS intended to "clarify" the rules surrounding split/shared visits – and in doing so created new rules and changed many of the existing rules:

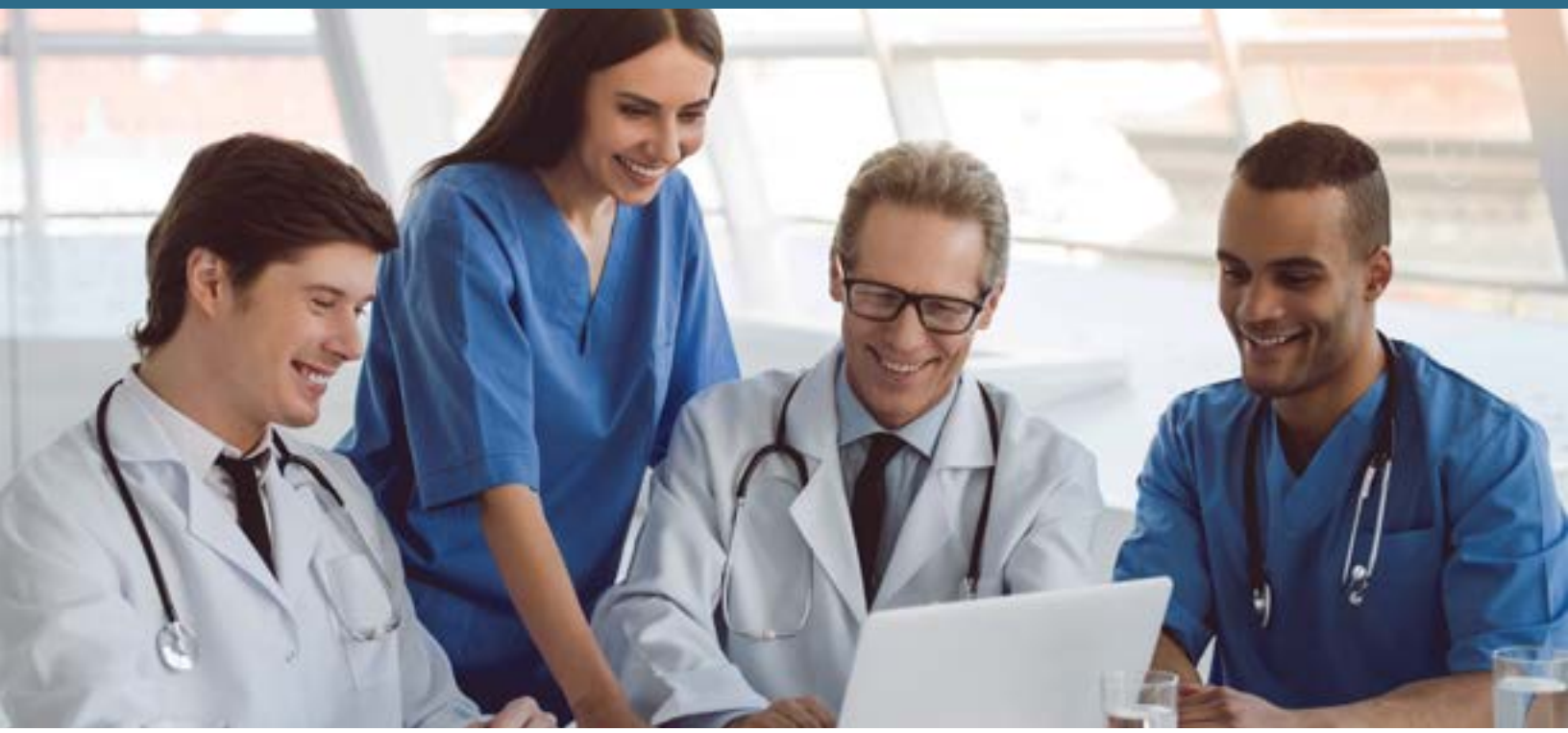
1 | The definition of a split/shared visit was clarified.

CMS indicated that a split/shared visit is an Evaluation and Management (E/M) visit in a facility setting that is performed in part by a physician and a non-physician practitioner (NPP) who are in the same group. The definition specifies applicability to encounters that occur in hospitals, skilled nursing facilities, or similar places of care – but not in offices. The Final Rule specifically indicated that similar encounters that occur in an office setting would be captured under the "incident to" billing scenario, not as a shared visit. The clarification allows us to focus on the specific care delivery environments that will be impacted.

2 | The CMS Final Rule expanded the patient types for which these visits apply.

Previously, split/shared visit determinations were only applicable for established patients. The 2022 Final Rule extended the applicability to new patients, both initial and subsequent visits, critical care services, and prolonged services – which expands the spectrum of patient services to be reviewed.

> The clarification allows us to focus on the specific **care delivery environments that will be impacted.**



3 | The 2022 MPFS Final Rule "clarified" the billing provider determination for these patient encounters – and aligned the new determination with their recent encounter coding documentation changes.

Previously, the billing provider had to have documented "substantive" participation in the encounter. Substantive was historically determined as performing significant portions of the history and examination – primary components for coding determinations under the 1995 and 1997 coding documentation criteria. With the 2022 MPFS Proposed Rule, CMS indicated the intent to change billing provider determination criteria to be the individual who dedicated more than half of the total time spent on the patient's care during the date of service. The "time spent" criteria were the same as the 2021 office-based coding documentation criteria and the new 2023 facility-based total dedicated time determination.

During the Proposed Rule public comment interval, CMS received considerable pushback about this change, which led to the introduction of a transition year with the publication of the Final Rule. The transition year permitted billing provider determination 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 required for the billing level submitted (except for critical care, which is solely time-based). CMS' acquiescence allowed physicians to continue to be designated as the billing provider – and receive full reimbursement rates – by documenting that the physician provided 100% of the medical decision-making for the interaction(s). The 2022 Final Rule stipulated that time spent would become the sole billing provider determination criterion starting in January 2023. However, continued public comment pushback in the 2022 proposed rule process resulted in continuing the 2022 transition year contingencies with the 2023 MPFS Final Rule. The 2023 Final Rule projected that time spent would become the sole billing provider determination criterion starting in January 2024. Time will tell if CMS sticks to this timeline – or acquiesces once again. Organizations may once again only have 6 months to prepare for the promised implementation.

DETERMINING THE BILLING PROVIDER IN SPLIT/SHARED VISIT ENCOUNTERS IS IMPORTANT FOR TWO MAIN REASONS.

1 | The reimbursement amount as was previously mentioned.

Designating the physician as the billing provider results in revenues at 100% of the Medicare Allowable compared to 85% for an APP billing provider exerting the same levels of effort and care delivery. The distinction can clearly have a potential impact on organizational financial sustainability.

2 | Workload credit and its direct impact on productivity-based provider compensation.

Many organizations attribute full wRVU credit for an encounter to the billing provider, which makes workload attribution straightforward and relatively automated. This practice does not fully align with ensuring that compensation is only awarded for "personally performed" services, however, as the APP's contribution toward the encounter and the level of service rendered is ignored. Ignoring the APP's involvement may not have been intentional as these visits were not identifiable in many organizations' claim submission process, and as such they would appear to be like any other claim that the billing provider submitted. Unless a proactive organization took extra steps to attach an internal modifier or distinguish between billing and rendering providers, they would have no way to determine that anyone, but the billing provider was involved in the patient's care. This factor changed with the 2022 Final Rule.

The 2022 MPFS Final Rule required that split/shared visits be identified with a specific modifier, -FS, when the claim is submitted. Internal business practices needed to change, and mechanisms needed to be created to reliably identify and capture these encounters with the -FS modifier. **The presence of a specific modifier allows these visits to be identified and internally and/or externally audited.**

Determining the billing provider as the individual who dedicated more than half of the time associated with the patient's care on the date of service creates a conundrum. Traditional APP utilization in these circumstances dictates that the APP spends more time with each patient so that the physician spends the minimum amount of time necessary and maximizes the physician's ability to accomplish more tasks efficiently. **By design, the APP dedicates more time per patient than the physician and would therefore become the billing provider much of the time. This impacts both professional services revenue and wRVU attribution.** Continuing to award full wRVU credit to the physician involved in these encounters becomes indefensible as the physician did not personally perform even a substantive portion of the care rendered. Thus, physician wRVU accrual will invariably be affected.

HOW MUCH THE PHYSICIANS' wRVU ACCRUAL IS AFFECTED WILL DEPEND ON THE ATTRIBUTION PROCESS ADOPTED.

If the conventional process of fully attributing the wRVU credit for an encounter to the billing provider is maintained, all wRVU credit for most split/shared visits would accrue to the APP and the physicians' wRVU credit would plummet. As previously noted, this method of wRVU attribution is flawed as it does not consider the other provider's contribution to the rendered service. Consequently, a different methodology should be considered.

Potential wRVU attribution methodologies to consider could include any of the following:

- **Create team-based productivity incentives.** This option pools earned wRVUs and distributes them equally among the involved physicians and APPs according to service or participation FTE. This model is relatively easy to administer but still results in physicians being credited with fewer wRVUs than their historic full credit.
- **Create an equal share of the split/shared visit wRVUs between the involved physician and APP.** Some organizations previously adopted this mechanism to promote team-based care and equally divide the wRVU credit to reflect that philosophy – and the "personally performed" aspects of the rendered care. This model is more difficult to administer but does accomplish its desired objectives. It also results in physicians being credited with fewer wRVUs than their historic full credit.
- **Eliminate, or significantly deemphasize, the productivity incentive component for shift-based providers.** This option applies primarily to specialties such as hospital medicine and critical care medicine. The model is well suited for providers who "cover shifts" and cannot directly influence their patient care volumes. This option avoids the split/shared visit issues but requires carefully considered rates to keep providers "whole."
- **Change the care delivery model.** This option was chosen by nearly 11% of the HSG Survey respondents. Options vary but the most common seems to be having the physician cover inpatient care on their own and have the APP cover office responsibilities during that time frame. This model keeps physician's whole for the inpatient care element but usually increases their dedicated time and effort to that patient population, perhaps at the expense of other opportunities (such as decreased office time).

An important point to drive home is that more than 65% of HSG provider compensation survey respondents indicated that they have not yet addressed the split/shared visit changes. **These organizations likely only have the next 6 months to analyze the impact of the changes by specialty, educate providers and staff about the changes and their impact, determine the most viable options to address the impact, and implement the most favorable options.** These groups cannot afford to delay the inevitable any longer.

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