Billing for Medicare G2211 – What You Need to Know Now– Webinar Transcript

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PYA Moderator 00:06
Thank you for joining us the webinar will begin shortly.

PYA Moderator 00:41
Good morning everyone. Welcome to the latest episode of PYA 's healthcare regulatory roundup Webinar Series. Today's topic is billing Medicare for G2211. What you need to know now, PYA is happy to present today's webinar on this important topic. You may submit questions during the webinar by typing a message into the questions pane of the control panel. Also, immediately following the end of the webinar, you will be asked to complete a short survey and submit any additional questions. We will respond to questions posed after the webinar via email we've posted in the handouts pane of the control panel a PDF copy of the slides for your reference. Also, you will receive an email later today with a copy of the slides and the recording of the webinar. With that I would like to introduce our presenters. Angie Caldwell, Laurie Foley, Valerie rock, and Martie Ross. Good

Martie Ross 01:32
morning. And thank you for joining us today. This episode of PYA is healthcare regulatory Roundup. I'm Martie Ross, a principal in PYA's. Kansas City office. And today to address the new G2211. Code that complexity add on code. We've assembled our a team starting with Valerie rock and a principal in our Atlanta office, who is expert in physician revenue integrity coding and billing. Laurie Foley also in our Atlanta office will bring the perspective of physician practice operations. And finally joining us the Tampa office is Angie Caldwell, who is an expert in physician compensation, design, implementation and valuation. So let's jump right into our agenda. We're going to begin with sort of some perspective

on how we ended up here. You know, my superpower is reading federal registers and trying to make sense of them. So I'll talk about how things evolve to January 1 2024. When this code first became reimbursable. Valerie will take Valerie will take over and discuss the basics. Then we'll move to Laurie who will talk about implementation strategies. And then Angie will bring us home looking at the physician compensation impacts. So let's start with how did we get here. And we have to go back to the summer and fall of 2020 not a place we necessarily want to visit that there we are back into the pandemic. With everything else going on Medicare, CMS published the 2021 Medicare Physician Fee Schedule Final Rule, which included some substantial revisions, to the e&m to the CPT codes for valuation and outpatient evaluation and management services. And this was really a continuation of a multi year initiative by CMS to clean up the e&m codes bring them really into modern times. And that included changes and how we determine the appropriate level for e&m services that take particular note of the last two bullet points on this slide. CMS significantly increased the WR views assigned to these CPT codes. And it also introduced the complexity add on code, which would be payable with these outpatient e&m codes with a valuation of just shy of a half of a RVU. In calculating the impact of this, CMS estimated that 90% of these codes would be built with the add on code. So expected a very rapid and robust adoption of this new code beginning of 2021. But we have to look at the impact these two changes would have on the overall Medicare Physician Fee Schedule. Remember, unlike every other payment system in Medicare, the fee schedule Physician Fee Schedule is does not have an automatic inflation adjustment. Instead, the amount of money we spend under the fee schedule is set by statute and to increase that amount requires congressional action. So CMS each year starts with a pie and it's all a matter of how you slice that pie up And that becomes the conversion factor. So if you increase the number of available RV use that are reimbursable. And you anticipate the use of those RV use, then we're going to if we're going to have, if we're going to pay for more things, we're going to pay less for each thing. So the impact of the e&m RVU adjustments, and the introduction of G2211, as well as some other machinations of the fee schedule, would have resulted in a 10 and a half percent decrease in the conversion factor for 2021. That was a $2.83 cent cut. So if you perform the same number of our values and 20, as you did, in 21, as you did in 20, you'd be receiving 10 and a half percent less in reimbursement. Obviously, in the middle of the pandemic, this was concerning. And Congress stepped in and the Consolidated Appropriations Act. Remember that monstrous piece of legislation that passed in December, late December of 2020, Congress stepped in and said, We're going to add more to the pie, and make some additional adjustments so that at the end of the day, rather than having a 10 and a half percent cut in the conversion factor, we would end up with a 3.3% reduction. To accomplish that, specifically, what Congress did was increase the fee for service pie by 3.75%. So that's a spending increase, then made adjustments to the Medicare sequestration because when in doubt, Congress will always make an adjustment to sequestration. And then importantly, for our conversation, they imposed a moratorium on CMS paying for G2211. Until January 1 of 2024. And thus, we close the door on G2211. And pretty much forgotten all about it until we find ourselves with the 2024 Medicare Physician Fee Schedule Final Rule. CMS with a moratorium lifted now says we're going to start reimbursinG2211. beginning on January 1 of this year, the valuation will remain the same as it was in 2021. At just shy of a half in our view, the work RVU is 0.33. That will become irrelevant when Angie runs us through some important math. That puts the national payment amount with the current conversion factor at $16. We'll talk in just a second about what's going to happen to the conversion

factor here in 2024. And we assume that Medicare Advantage will cover this new code at the rate negotiated by the parties in their contract. There's a course of redistributive impact of now reimbursing for 2211. So to calculate that impact, CMS now assumed that 38% of all patients the outpatient e&m codes, would you build with this and 2024, eventually increasing up to 54%. So they assume slower adoption, and having the code apply to fewer services. And Valerie will walk us through the changes introduced to 2024. The result in that so we go from a 90% assumption, and 2021 down to a 54% assumption for 2024 as this code is being implemented, of course, adding that new reimbursement into the pool means that you have to Slice the Pie differently. That means that by reimbursinG2211, there's going to be a 2% reduction in the conversion factor as compared to 2023, approximately 70 cents to pay for this change with the addition of G2211. Remember the overall reduction this year in 2024. The conversion factor in total is 3.34% or $1.57. As you can see about two thirds of that conversion factor reduction in 2024 is attributable to the introduction of reimbursement for G2211. So what's that mean? It means you need to build G2211 To make up for the reduction in the conversion factor. And that's what we're here to talk about is when is it appropriate then to bill for 2211 so that you don't see this reduction in your Medicare reimbursement. Of course, there's always Congress and when they could step into this, or well, okay, leave it at that. We are as you know, in a extended process of budget negotiations on Capitol Hill, certainly it is in the mix to correct the conversion factor going forward. There is read legislation that has been championed by the AMA that would revise the conversion factor to include an in an inflationary adjustment by only going forward but will See how that all plays out? Okay. We previously had circumstances where the conversion factor going into effect on January 1 was lower Congressman stepped in and increased the conversion factor. And CMS went back and paid retroactively that increased conversion factor. So that's still on the table. A question is, how will they pay for it? And will that again be a cut of G2211. Certainly, in the comment period, when the proposed rule was published, we saw a division and the physician community, because we had the academy, American College of radiologists, the American College of Surgeons, several others special surgical specialty societies coming out against 2211. On the other side, American Academy of Family Physicians championing this code. That's all settled down. Now with the final rule publication is everyone's saying, just increase the conversion factor. But I will just say there is that possibility out there that Congress cuts off 2211 as a way to pay for the conversion factor, it's on the table. It's not necessarily on the table, but it is an opportunity. So with that, let's turn this over to Valerie to talk about the basics of this role. Not a role. It's a code, sorry.

Valerie Rock 11:20
Okay. It's pretty significant code, obviously. But I'll tack on to what Martie was describing with this determination of what the valuation would be of the service and how to adjust the conversion factor. And what you'll see in the final rule is that they're actually trying to contemplate the utilization of this code, as opposed to the allowed utilization of this code. So how many people are actually going to use this so that we don't reduce the conversion factor over, you know, too much to the point where, you know, it's Medicare's advantage of this, you know, low utilization of the service, and that they're just paying less overall for all of the services. So keep that in mind. Because just because they're contemplating certain things that would like reduce the utilization of the service doesn't necessarily mean that there's a limitation to your utilization of it. So we're going to talk about and dissect this code,

because the language in this code and the language that is used to support this within the manual, and that you'll see, you know, throughout even through Matt guidance, and things like that are really important to understand, and really understand also the intent behind the code, because if you get lost in the language, you can head down a road that is not intended. So let's start with a descriptor. The descriptor has two parts. And it's important to understand where these two parts start and end. Because if you look at it the wrong way, you could interpret this completely differently. So the descriptor for the G2211 is visit complexity inherent to evaluation and management associated with the first part. So we're starting with visit complexity. So the complexity of a service related to e&m services are our evaluation and management visits, and specifically our office and outpatient and services. So these 99202 through 99215 are the only codes that we're talking about for this service. So your office based services, one with medical care services that serve as the continuing focal point for all needed health care services. So you're in a primary care setting, and you're the primary care provider, you are the focal point of all services that are rendered for that patient. So you're, you know, referring out to other specialists and you know, making sure that care is performed and following up with the patient. And you're that continual focal point, that is the first scenario. The second scenario is with medical care services that are part of ongoing care related to a patient's single serious condition, or a complex condition. So we've got a specialist type of scenario where we're providing ongoing care, but it is for a single serious condition or a complex condition. Medicare wanted to clarify in this final rule that this is for a serious condition, not just a single condition. So that is one important thing to note is that we're talking about something a little bit elevated than, you know, a single just kind of routine, you know, kind of a one and done you'll see that language that appears routinely and later on in the presentation. But what really what we're looking for is two scenarios, specialists and primary care providers. ers that are likely predominantly serving the patient in the office or outpatient kind of clinic setting. And their predominant services are these e&m services, because they're getting paid and reimbursed on these e&m services. And they don't have the all the procedural services to supplement what they're doing. And the argument that CMS and authors that are writing the final role are saying is that they believe that these office based scenarios are not reimbursed at the level that they should be such that when we revise the work RV use in 2021, they still didn't increase to the level that would be necessary to pay for these types of cognitive services that are occurring in the office based or clinic based setting. And that these specialist services are in fact, over paid. And so that we've got to regulate this back to something that is or to something that is going to make more sense to make sure that we're paying for these services. And what you're seeing is still a push towards value based and bundled payment. But we're still in this fee for service world. So we're trying to get towards something and value things that are happening outside of your normal visit and fee for service just face to face encounter. So they're they're trying to bolster that. But one of you know, these bullets at the bottom of the slide are all of the things that we actually know at this point. So it's built again with those office based e&m codes only. It's not limited to specific specialty so that while yes, the intent is really to cover these specialists that are really heavy on these e&m services. It doesn't limit other specialties from billing this. It can be billed by your non physician practitioners, your NPPs or a PPS you can build this under their NPI. You can also include this with your telehealth services. So you're billing an e&m on the same, you know, via telehealth, then you can include this G code, but it's not available for Rh CS and FQHCs. Because of

the methodology, that that's paid for. It's an all inclusive rate. Tomorrow, it will go to the next slide. Valerie,

Lori Foley 17:23
one thing I'm sorry, I know, just for folks that are looking at it going gosh, I didn't notice the one and the two, we added that for emphasis, because we really wanted folks to understand those two criteria that you talked about. Right? Right.

Valerie Rock 17:35
Because if if you move that, you know, those phrasings over any, and you assume that the secondary part includes this focal point of service, then you're missing the concept between the two ideas. So yes, again, we added that Thank you, Laurie. So when we look at the objective view of when we cannot build this, we have a push towards the 25 modifier. So the 25 modifier allows us to bill for procedure, in addition to an e&m on the same day. So that 25 modifier overcomes the Edit against the e&m with that procedure that day. So what again, this concept of if we have procedures, if we have a proceduralist focused provider, we're not intending to pay for this service and above and beyond that. So if you have a heavy proceduralist provider, you may not be looking to build this, but it doesn't exclude you, or preclude you from billing it. One thing to note is that in the original fact sheet that was produced in 2021, associated with the release of the G2211, there was mention of payment modifiers that would not be assumed that these G codes would be built with. So that included the 24 and 53 modifier. So keep in mind that there may be other payment modifiers. That may be a risk to build. But when we look at the change request that came out at the end of the year, that will eventually be applied around February 19. It will be applied to our Medicare claims processing manual, you'll see that the 25 modifiers, the only modifier they include. You'll also see a lot of information from your Mac's that say that they're including an edit against the 25 modifier. So the absolute edit that's intended at this point is the G2211. With your e&m with the 25 modifier. So if you're also doing a procedure on the same day as the e&m, you will not be able to build that so you'll probably want to go ahead and build that type of edit in your own system.

Martie Ross 19:50
You know, Valerie This is why you see that utilization change from the assumed 90% down to the high 50s Because in 2021 See AMS ad, we would expect not to see the code bill with the modifier 25, but did not have this explicit prohibition that shows up in 2024. Right.

Valerie Rock 20:11
So then the subjective portion, which is the reason why you're attending this presentation, is that the service built by a practitioner who does not intend to have an ongoing longitudinal relationship with the beneficiary would not build this service. So you would have to get into the mind of the provider and determine if they intend to continue to see this patient in order to do this in an automated fashion. And that is the complexity of this service. So how do we actually implement this in more of an automated fashion, because it's going to be very difficult just to train providers to utilize this code at the right time

and the right place, etc. So we understand that that that is really the issue. So let's move on to the next slide.

Valerie Rock 21:05
So again, we have these two options, we're really looking for this longitudinal relationship. For primary care, the provider is that kind of hub, the spokes are all of the specialists, and the primary care physician is that performing provider who's saying, Okay, I need to take care of this patient for all of their care, and I need to manage the patient, you know, longitudinally, and I need to have a relationship with this patient, such that they're going to come back to me when they need services, so that I can manage all of that care, and that when they go to a specialist, I'll still be kind of managing how that's going and making sure that they're following up and all of that. For the specialist side, again, we're talking about ongoing care. So it's still one longitudinal relationship, they may be coming to you. And they're, you know, you're determining that they have a certain diagnosis is a serious diagnosis. And so we're, you know, continuing to manage this patient longitudinally, an ongoing basis and making sure that this patient is managed appropriately, it does not necessarily mean that it's a team based approach. So the team based type of language is really on that primary care setting. Whereas the specialists may be the only one managing this patient for the service, but the cognitive load to make sure that the patient is returning and following their plan of care and following the services that they need. And making sure they're they're compliant with the treatment is the server is what they're paying for. In this G code. The documentation is the hard part, right? So when the when CMS is talking about documentation, they go back to well, you're billing an e&m. So you have to support the fact that you're you have medical necessity for that e&m, you have to support the medical decision making or time that is supporting the level of service build. But they say there's no additional actual documentation that's required, though, what you'll see in the language is that types of language like plan of care, or assessment and plan, the diagnoses that you're managing the other services provided that are kind of, you know, creating the complexity of the visit there. So the specific visit itself, however, does not have to show some level of complexity, it's that the patient, you may be providing acute care one day and chronic care the next day, but it's the longitudinal relationship with that patient that really matters. So let's look at the next slide. And see a few examples that are provided and an mln update that was recently released. So the first one you see is sinus congestion. So PCP sees a patient for sinus congestion, I think what they're saying to you is that it really doesn't matter what they're seeing the patient for this could be a self limited or minor problem. But because the patient needs to be managed, and because that provider has a relationship with that patient, that is managing more than just that sinus congestion, they're managing the entirety of that patient, making sure that patient is going to come back for their annual wellness visit, making sure that patient has all of their, you know, routine needs taken care of and that maybe they do have a condition that they need to go back to their specialist to see are they really being compliant with that, that visit, you know, would include all of those pieces because it's it's your chance to actually make sure that all of those things are happening. So it really doesn't matter. Again, what that the diagnosis is on that claim is the fact that you're needing to have that relationship and that you do have that relationship with that. patient. When we flip over to the specialist side, we see a complex or serious condition in HIV, and HIV. In this situation, the patient's missed several of their medication doses. So they're not compliant with their medication. But the

provider would not have known that had they not had a relationship with that patient and the patient came clean with the fact that they've missed some of their medication. And so they are working on that relationship. And that is the cognitive side of the of the discussion, and the medical decision making that's going on inside the head of the provider, that the that this code is paying for. Now, that raises the issue with this documentation, because oftentimes, you're not going to be documenting the psychosocial type of issues that are going on with your relationship with the patient, or with that patient, that that may be something you don't want the patient to see ongoing. We see this oftentimes on the on the psychology side or psychiatry side, that there's some things that just don't go on the record. But you still have to show at least some type of continuity with this care to say, Yes, I'm managing this patient. And yes, they've missed some of their medication. And so we're trying to make sure that they're getting back on track. So I want to see them again, in a month or two, that kind of thing, you're going to see those follow up visits, which I would focus on is when do I need to see this patient again, and including when, and why? You know, I need to see this patient again, further AWB or I need to see this patient again, and three months to follow up on this issue. And showing that need to see that patient again, will show that relationship. So let's look at the next slide. So we're starting to see some mac guidance. And what you'll see is that this language that is displayed, and especially highlighted is some of it is a little bit more than what we've seen in the final rule, but a lot of it is in the final rule. It was also included in the fact sheet that was out in 2021, then applied to the Medicare claims processing manual around that time. And in 2023, we do not have the full update again, within the Medicare claims processing processing manual that will happen in February 19. That change request includes the new language that includes a lot of this language. So ongoing care that results in care personalized to the patient. So personalized to the patient is usually something that you hear when you've got a copy and paste scenario, we have a problem with issues with documentation where we just see the same care provided every single time the Medicare contractors want to see and Medicare wants to see that you're personalizing the care to the patient, that this patient is being truly seen for this issue on this day, and that you're managing them for all of these other things going on. That it's comprehensive. Again, this kind of concept that is more on value based care, where you're actually managing everything that's going on, you're following up on what's going on with you know, they went to the GI provider and now you know they had a endoscopy, how's that patient doing? Do they need to come back to you for additional care you're following through with all of that care, but that is outside of the service, that name may not qualify for chronic care management, it may not qualify for principal care management. But what this describes in the final rule is that this is, you know, addressing services that are not qualifying for CCM and PCM. But that are indeed services outside of what is paid for today. At the bottom here we've got every patient would be unique with their health care needs. And templated language for add on code may not support medical necessity. So what that saying is, please don't add a line in every single note that says I'm providing the longitudinal comprehensive and continuous relationship for this patient. Because it's not necessarily going to support that you are you have to reflect it in the record that you are actually providing that. And again, I think the follow up timing and what the need is in your in your CC your chief complaint, you want to make sure that you're saying you know now I'm seeing the patient for follow up for this condition and what's going on today a patient complains of this and this is what's going on. So you're showing that that continuity of care. We've been asking for this for a long

time in the record, and EHR. ours made it very difficult to get this into the record. But this, this G code will all the more give you reason to add this kind of context into the record.

Martie Ross 30:12
So Valerie's fair to say there's no more work involved. It's just how you capture what you're doing and the Medical record documentation to support the code, right.

Valerie Rock 30:21
And it can be inferred, right. So like, it doesn't necessarily have to be explicitly detailed within the record, you just have to show that you are, in fact, providing that longitudinal care, but it only has to show one visit, because your one visit may show that you have intent to provide long term care for that patient. That's all you have to do. So it's that one, that one visit is going to be the most difficult to support. Having multiple visits, especially during the year Lee at least annual visits will show it better. But you don't have to necessarily do more work. Well, you don't have to do more work. They're saying they're trying to pay you for the work that you're already doing.

Martie Ross 31:06
So if you're like us, you have a million questions as to how this is actually going to be implemented. And where are the risk areas? And how does it apply in specific circumstances. And let's go back to January 24, where CMS had its open door forum for physicians, nurses and allied health professionals, if you're not familiar with the open door, open door forums, these are sort of semi regular calls that CMS sponsors with experts from the agency, who will introduce new new initiatives, introduced new mln articles, and then open themselves up for questions. And this is in this open door forum. They introduced the mln article that Valerie discussed. And then a very, very person named Eric Carrera from CMS took to the lines to answer questions that people posed now, and in preface to answering this question, he said that they have received numerous inquiries through the Medicare Physician Fee schedule.cms.gov, that with that email address you can send questions to, and that they are in fact planning to publish a comprehensive FAQ on 2211. It's coming soon. We haven't seen it yet. Also note that there was no the transcript has not yet been published for the January 24 opendoor. Forum. So what we're going to share here is Martie's best recollection. She's getting older. So we kind of worry about Martie's best recollection. But I was carefully taking notes, and only included here what I was quite certain I heard. So let's go down some of the topics and questions that were asked during that open door forum for some insight. And number one was, can you build this code with new patients? Because how do you have a longitudinal relationship with a new patient? Well, it's very obvious, you can build a code with 2211, because they included the new patient codes as part of the purview of this particular code. And so what CMS official said is, if the teacher and practitioner anticipates that they're going to be assuming this role as a focal point, either as the PCP or to manage a specific condition on ongoing basis, then it would be appropriate to Bill 2211 We'd be looking for things like documenting an assessment and plan. Are you ordering tests? Are you scheduling subsequent visits and the like, all of that is going to support 2211 Not necessarily required for 2211. But if it's more of a second opinion, as the reason you're seeing the patient, if it's a one and done and that language was used frequently, during this open door forum, if it's one are done, then it would not be appropriate to see to a bill 2211

The speaker emphasize that CMS does not intend to dictate or direct how patients are managing your practice, they're not going to say you have to order this test you have seen this frequently, instead, or that you have to at least see them once annually to have a longitudinal relationship with the medical reviewers are looking for is is the practitioner providing care consistent with the practitioners usual practice for managing a patient over time? And so that becomes the key there. Valerie, I'll let you take the next one.

Valerie Rock 34:34
All right. So when we talk about primary care provider, or the provider, that is the specialist seeing the patient, it's easy to say okay, well, that's the provider that's doing that. But what if you have a provider that is the primary care provider and he goes on vacation, and that provider while on vacation has a physician within the practice? That is Seeing patients in his stead. So if you have a physician seeing a patient in that primary care provider stead, then you could build the G code, because that provider is serving in that physician stead. Similarly, if you have a non physician practitioner and NPP are a PP, that is providing services incident to that physician, but of course, we have to Bill, the incident to service under the supervising provider that was actually in the office, then you can still do that, because that NPP is providing their services incident to that primary care provider service, even though you're billing under a different provider. So what we have here is this kind of practice, not the practitioner concept, but also, it's as if you have that one identified provider, but the provider providers in the practice are providing service when that other practitioner is not available. So, and that would still allow you to build that G code. Yeah, that

Martie Ross 36:05
in the discussion, he made specific reference to this established patient criteria, right, seen by, say, by a physician in the practice on the same same practice, same specialty within the last three years sort of you referenced specifically that established patient standard, or considering when it's appropriate to Bill 2211. Right.

Valerie Rock 36:27
So then, the residents scenario that was mentioned during the open door forum was also considered allowed. So the question was, can you build low level visits for that primary care under the primary care exception for the residents. So, in this primary care exception, of course, you have a proctoring physician, who is present in the suite, and the resident is allowed to see low level services for you know, independently, basically, the physician does not have to come in on the proctoring physician does not have to come into the office, you know, into the suite into the actual room with the with the patient and does not have to document, you know, part of the visit or key components of the visit. So, because of that, that was the question there. But this is similar to the last scenario, where the provider is providing something incident to that primary care physician. So you have a proctoring physician that serving is that oversight and that lead in the care of the patient, and then you have the resident kind of serving as a proxy to that physician. And so, then you're allowed to build that G code because of that scenario. And I think if you can think of it like that, then it doesn't matter what the scenario is, you can build that G code.

Martie Ross 37:55
There's a question asked by a rheumatology practice that if the rheumatology practices managing a patient, does that qualify as being the focal point for 2211? Again, the response was, we're not going to provide you a list of serious or complex conditions, we're going to instead look to the Medical record documentation that to indicate whether the condition itself is going to require ongoing medical management. One thing to note here, though, is I think, and Valerie point is at the beginning, the code has to pass the focal point and ongoing care, focal point goes to primary care, ongoing care goes to the specialist. So in this case, it wouldn't necessarily make the rheumatologist the focal point of care, but instead providing that ongoing care whether it be for rheumatoid arthritis or lupus or the like. We also had a question regarding the frequency of how often can you build 2211? Again, the response was there are no limits on the frequency of building the code and attaches to the nm service. Nor is there any requirement is the minimum frequency the to see the patient to build for 2211. There was one where the CMS official just took a pass, when they were asked the question, can you build 20 to 11? On the same day that develop prolonged care code. And the response was, we'll address this in the FAQ. So it is good. It's It's It's appreciative we should be appreciating, they are taking this very seriously thinking through the implications as they wait to publish the FAQs.

Valerie Rock 39:32
Though, I think Martie, I think we will likely see the prolonged care code excluded. So the if you build prolonged care that that it wouldn't be allowed because the concept of that day's service being increased based on that prolonged service as opposed to CCM and PCM types of services where it's like truly, outside and like through the month type of service versus This cognitive load on that day. So so we'll see how this turns out. But at this point, it's not precluded from from billing.

Martie Ross 40:11
Questions on documentation, again, just targeting back to how Valerie described this. There are no specific magic words, no new documentation that's required. And again, the focus in the medical review would be on the mend visit documentation. And whether that's reflecting ongoing care or this again, this term one and done visit, because our concern is the distance between one and done and launch it to, you know, ongoing care, how far do we get between the two, but that's where we have the gray space at this point. Finally, a question on team based care. It was a very specific question, because it was asked by the caller was a part of the transplant program. And they said, as part of our transplant program, we have team based care, can all the team members then Bill for 2211. And the response was, if the team members are actively participating in that patient's code, it'd be appropriate to include the add on code on services they provide. Get a very specific example, on team based care. It'll be interesting to see how much broader CMS is willing to take this on this on the team of providers managing a patient's care. Okay, enough on the nitty gritty details of what this looks like, let's turn this over to Lori, to add some practicality to this discussion.

Lori Foley 41:31

Thank you, Martie. There are still many nitty gritty details, even as we look at implementation considerations. So presumably, this doesn't change. I think Martie and Valerie covered pretty sufficiently that this doesn't really change how providers see their patients. And we've clarified that there are no specific documentation requirements. But it does require those considerations of the providers relationships with the patients. But it would require changes in billing processes. So if we break it down into a couple of different buckets, I think the first one is really when to implement it. So we've referenced that these FAQs are still outstanding. We know they're coming soon, to quote Martie in the air quotes, but we don't know what soon looks like. And so, you know, is there enough information for you to confidently move forward right now, if you're on the fence, we would generally recommend waiting for that soon-to-be-released FAQ. But if you're a go, if you're already implementing this, or you're close to implementing this, then we would encourage you to capture your basis for that approach and your considerations. And then document how you are operationalizing this into a written policy and procedure, then obviously, when new information comes out, you know, we'll be writing on it or talking about it, it will be well covered. And make sure at that point that you are revisiting your policy and procedure and that you'll make some updates accordingly. So then if we flip over to think about who we want to implement this for, I know Valerie referenced early on the Medicare Advantage. Maybe Martie referenced the Medicare Advantage coverage, considering that G codes are CMS codes. So they may or may not be adopted by other payers, it's in their discretion to do so. There aren't specific rules as to whether the MA plans will pay for the code because, you know, some may adopt coverage from a fee-for-service contract. But if your providers your MA plans are under a value-based or capitated rate, the MA plan may determine that this is already considered in that rate. So we don't know for certain what that will look like in a true payment-in-the-door kind of scenario. Keep in mind that commercial payers have the option to adopt or not adopt, it's at their discretion and the same for Medicaid. So at the end of the day, what we know is CMS will cover it for traditional Medicare, and then the others are maybes at best. So then that shifts over to considerations really on how to implement it. And so you first have to decide based on you know, kind of what we know where you will fall on are we going to submit this code across all applicable visits, regardless of the payer? Absent other information or guidance at this point. There are a couple of impacts that you have to think through in your evaluation of that consideration. We'll get the increased reimbursement for Medicare, you may get increased reimbursement from other payers, and you may increase your write-offs or your contractual adjustments from payers who do not pay. Since it's a noncovered service, perhaps for them that may mean that it's not a separately billable service to the patient, unless you follow your contract protocols for patient notification of non covered services. So you would have to evaluate that Put in a process to get that patient consent most of the time in writing have that documented and available if the payer were to non cover it, and you wanted to build a patient, there may be a change to your gross collection rate and your accounts receivable if you are adding these services and thus the charges, and perhaps not getting across the board reimbursements. So as you're evaluating shifts in your gross collection rate and your AR balances, you just need to monitor to see if you need to reset for a corrected expected rate on those two, two key performance indicators. On the other side, though, you really shouldn't see an impact on your adjusted collection, right, remember, that already takes into account you know what you're collecting of the collectible dollar. So it already takes out the impact of those contractual adjustments. So you're you shouldn't see necessarily a change in your adjusted collection

rate. If your providers are paid on our work RVU model, you will see an increase in those work RV use. But depending on your payer reimbursement, you may only receive in increase collections for a portion of that volume. So Andy's going to dig into those considerations in just a few minutes because there are several that you will need to work through. If you're trying to, as we're thinking through, we've talked about, you know, how we're going to, you know, consider for all of your patients, or we're going to do just certain just straight Medicare, for example, it's trying to figure out then how to determine when to physically build the service. So we spent a lot of time discussing the operationalization of this, how would you process it? So for example, would you have your practitioners decide at the time of service that this service qualifies for GE 2211? And if so, how would they notate that? We don't have to have specific documentation in their record, might they have a checkbox in their documentation that would be predicated on your EMR functionality. And then obviously, training your providers to be thinking about that. And then checking it consistently gets a little more complicated. If you're only doing it for traditional Medicare, and you're not doing it for other other payers. It's hard to operationalize just for one subset of your patient base. You could have your billers review documentation and apply the code, you know, on a one by one case by case basis, that'd be pretty labor intensive, especially because they may not be reviewing all of the e&m in that scenario, and again, trying to figure out a way to effectively operationalize it. Depending on your EMR structure, you could potentially set a rule. You know, if this then that scenario, again, predicated on the decisions that you made through the earlier analysis. from a risk perspective, we feel like a conservative approach would be to build this for if you wanted to take a baby step to only bill it for established patients, because that would define a more clear longitudinal relationship through that repeat visit, process. But again, Martie just covered a few minutes ago, you can build this for new patients in certain circumstances. So again, it's a risk tolerance consideration there. We also were talking about if you are providing care management services, such as chronic care management or principal care management, then you you have clearly established a longitudinal relationship with that patient. And could be even a more conservative approach. If you just you know, started with your CCM PCM roster, as you started to have and visits with those patients that you've, you've got that confidence that you you've been able to support that relationship. Regardless of all of those, again, documentation will be key, especially when we're in those scenarios, we're changing information. So based on what you know, right now, here's what you were determining to do. within your practice, here are the policies and procedures you're going to put into place as to who you're going to Bill, how you're going to bill when you're going to bill, documenting all of that, providing good effective training for your providers and your staff, monitoring for updates, and then refining those policies and procedures and training, just rinse and repeat as you have new information, making sure that you're staying current with any changes that we get through through subsequent updates. So I think that, you know, you've got a lot to consider as you evaluate where it falls for you if you're an early adopter, or if you're going to wait and be a little bit more measured in your approach. But at the end of the day, documenting all of those considerations will be will be important, and then just staying on top of it as more information comes out. Angie, how about we dig into the compensation considerations because I think that's going to be interesting for folks. Yes, but wait,

Angie Caldwell 49:45

there's more. Right. So we've talked about the revenue integrity side of this. We've talked about the compliance side, the coding side, we've talked about the operational side of this implementing this code. So now let's talk about out physician practices and how this may impact your physicians. So we're going to take this conversation and take to the end of the discussion today, really in two buckets, one, independent physicians and then two. Secondly, hospital employed physicians. So let's start with independent positions first. So the economic alignment of this change is a little bit more clear on the independent physician side. So to the extent that you are able to build the code, there is an increased reimbursement to your practice. As Martie shared earlier, that increase to your practice for billing that code for Medicare patients is $16.05 per code. So that multiplied by the number of times that you're using that code within your practice is going to be the pickup to your practice and a direct impact to your bottom line. PYA A's estimation. And if you follow along with me, and this is a estimation based upon several assumptions, if your assumptions in your practice are different than the numbers will change. But let's assume a patient panel of about 2500 patients, let's assume that your Medicare and Medicare Advantage, let's assume that Medicare Advantage is also going to allow for this code is about half of that. Let's assume earlier in the presentation, we talked about about 40% of this time the code will be used. So let's use that. And let's assume four visits a year related to this particular patient. So in this instance, this physician is going to have about 2000 visits a year related that wouldn't be able to billing the G2211. At $16.05 Each, that's the national reimbursement. So that's another assumption that the audience would need to take into consideration that your reimbursement may be different. But then that's an additional $32,100 to your practice, estimated. So then what can you do with that is an economic benefit to your practice, that could be used to pay your physicians, it could be used to invest in the practice related to other value based models and preparing for or value based models. The increase in reimbursement, it seems is what CMS has intended to do is to allow more compensation for the care, the longitudinal care of the patient under this code, so it's much more direct for physician practice. Primary care physicians and medical specialists are going to see that $32,100 amount that I shared a moment ago proceduralist, it's going to depend, it's going to depend for the procedurals, how many G 22 elevens that they're able to bill. And will that offset the conversion factor reduction that we talked about? Almost an hour ago now, when we talked about that that reduction. So for your procedure list, in private practice, it's a little bit of a different economic model, and may not be the increase to your practice that our primary care physicians and medical specialists are going to potentially receive from this, so many of you will move forward. So when we think about the hospital-employed physicians or contracted physicians, the economic alignment model becomes a little bit more complicated, right? So about 65% of physicians are paid on a productivity-based model. So work RV use. So if we think about the work RV use related to the G 22 11.33. Work RV use. So in this discussion here a moment ago with independent physicians, we were focused on reimbursement collections into the practice at 1605. Now that we're on the other side of the brain, talking about an employed or contracted physician, we're talking about work our views. So work RVU is point three, three for each of those, those codes. So again, if we take our example a moment ago, and just pull it through to the employed physician 2000 visits a year, at point three, three work RV use each that's about 660 additional worker bee use for a primary care physician, if we assume about a $50 conversion factor compensation per work RVU for each of those 660 Work RV use, that's about $33,000 additional additional compensation to that physician for that work. Okay, this is just an example. So this is where decision-making comes right no

One, the increase of compensation to the physician, the first question to ask is, is the practice receiving reimbursement to offset that additional compensation to the physician, my math indicates that the break-even conversion factor, I use 50. In my example, at 50, you're losing slightly on every work RVU using that 1605. Reimbursement national reimbursement, the breakeven conversion factor is about $48.64. So if your conversion factor is over $48, bless you Mardi Gras over $48.64, then you are losing slightly on contractually between your reimbursement and your compensation per work RVU paid out under $48.64 or work RVU, you're not, you're not losing on that code, you're not paying out everything to the physician that you're receiving in reimbursement. Keep in mind that my example just now was focused on only Medicare or Medicare Advantage patients. So in the employed and contracted physician scenario, to the extent that the physicians are using the G2211. On for all patients running through your system, then point three work we use is accumulating in the work RVU attribution for the physician without potential reimbursement offset, because again, in my assumption, we are receiving potential reimbursement offset from Medicare and Medicare Advantage. So that will be something that you'll need to consider related to this code and the work are the attribution as to you know, are you going to accumulate work or reuse for all payers? Or are you just going to accumulate this code and the related work will be used for CMS and Medicare Advantage and the payer and the payers when they decide which payers decide that they will actually pay for this code.

Angie Caldwell 57:16
So we need to be thinking through these things. And again, you know, we talked about there was conversation within our time together, about the purpose of this code, CMS is recognizing that the work is being done, and they're trying to reimburse for the work that's being done. So philosophically, from the employed and contracted physician side of things, your philosophy needs to be developed as to whether you are going to pay the physician more for work that was already being done. Or you're going to go along with CMS and say, This is work that was not previously compensated, and now there is a potential catch up for that work being done. And how are you going to accomplish that catch up from a physician compensation perspective all at once? Or do you want to choose a budget neutral approach? So if we think back to when all of those e&m Work RVU changes occurred? Substantial that was substantial for our physician practices and our hospital employed and contracted physicians. And at that time, many of you froze your work RVU attribution and accumulation to the 2020 Medicare Physician Fee Schedule, so that you could implement some budget neutrality measures from a physician compensation perspective. So this is not to the extent of that change that occurred in 2021. But it is something to pay attention to, from both a financial statement, a practice Income Statement perspective, as well as a physician compensation perspective. I've focused my conversation in my examples on the primary care physician physicians in the medical medical specialists, and not so much the procedure list, same thing goes here. But to the extent that the procedure list is using a G2211, it is likely that their work RVU conversion factor is higher than 50. So we need to be thinking about that on the hospital employee physician side, understanding that it is not likely that the reimbursement will offset the procedure less use of that code, however, but we know that the collections have also gone down overall related to that Medicare conversion factor. So a lot to consider. From from a physician perspective, this is a gift This G code is a gift that that does keep on giving. And there are many facets

to understand regarding it's the process and implementation. Martie, I'm going to turn it over to you to wrap us up. Before we say

Martie Ross 1:00:15
is it just interesting that you know for CMS is just one pie, and it's how you cut the pie. And so if you increase compensation to primary care, it's going to decrease compensation, just procedure lists. For those who employ physicians, that's probably not an option. So the implementation certainly will be more challenging. Well, that wraps it up for GE 2211. as Valerie said, as new developments come out, we will certainly be commenting on that keep you up to date as much as possible. future healthcare regulatory roundups upcoming, just a second, get there. Oops. It always jumps too far, doesn't it? They were 21st. I'm going to be joined by Tracy wall, we're gonna talk about opportunities with rural health clinics and their changing regulations of reimbursement. And then on March 6, we have a true treat for you, Barry Mathis will take over the microphone and talk about changes to federal and state cybersecurity landscape, some new guidance that came out this month, and we'll delve into that deeper provide some really practical, useful guidance for you all of those matters. So with that, back to UK lunch, take us off.

PYA Moderator 1:01:26
Thank you so much. And thanks to our presenters Valerie Martie, Laurie and Angie, just please remember to stay on the line once the webinar disconnects to complete a short survey. Later today you will receive an email with their contact information and a recording of the webinar. Also, the slides and recordings for every episode of PYA's healthcare regulatory roundup series are available on the Insights page of PYA's website, which is pyapc.com. While on our website, you may register for other PYA webinars and learn more about the full range of services offered by PYA. Please remember to stay on the line once the webinar disconnects to complete a short survey and post any questions you may have. On behalf of PYA. Thank you for joining us and we hope you have a great rest of your day.