



# Timely, Tough, or Tricky – Physician Compensation and Fair Market Value Topics in 2022

GROUP PRACTICE EXCEPTION CHANGES AND APPS

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April 7, 2022

# Speakers

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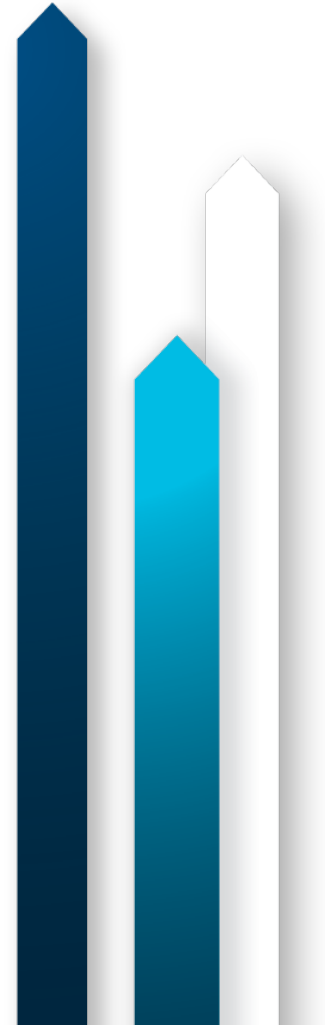
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# Introduction

- To begin a dialogue on timely, and occasionally, tough or tricky topics in physician compensation and fair market value, PYA surveyed more than 30 physician compensation experts to understand the collective thoughts on issues impacting these topics in 2022. These issues include:
  - The 2021/ 2022 Medicare Physician Fee Schedule
  - Telemedicine
  - **Group Practice Regulatory Changes**
  - **Advanced Practice Practitioners**
  - Value-Based Compensation
  - Confusion Surrounding Compensation per wRVU
  - Using Benchmark Data in 2022, Including COVID-19 Implications
  - 2021 (and Beyond) Changes to Commercial Reasonableness
  - Rural Physicians
  - Integration of Independent Physicians in Employment Models
  - COVID-19 Impact on Call Coverage Compensation
  - Other Hot Topics (to be determined by webinar series participants, changes in market conditions over 2022, etc.)



# Group Practice Exception Regulatory Changes

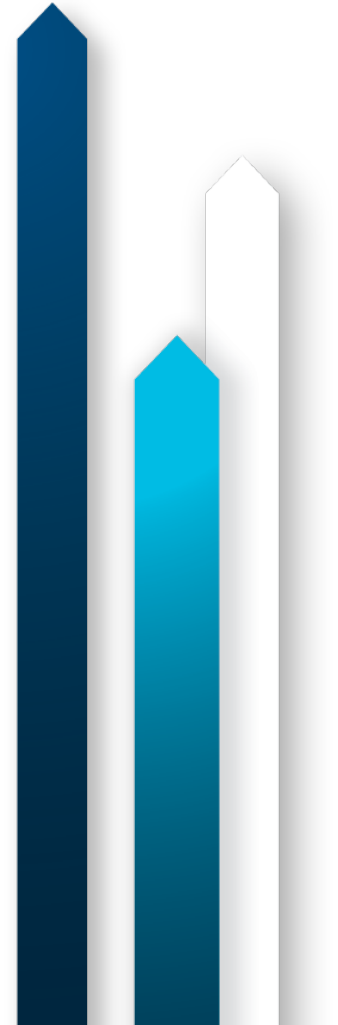
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# Why is the Group Practice Exception Important?



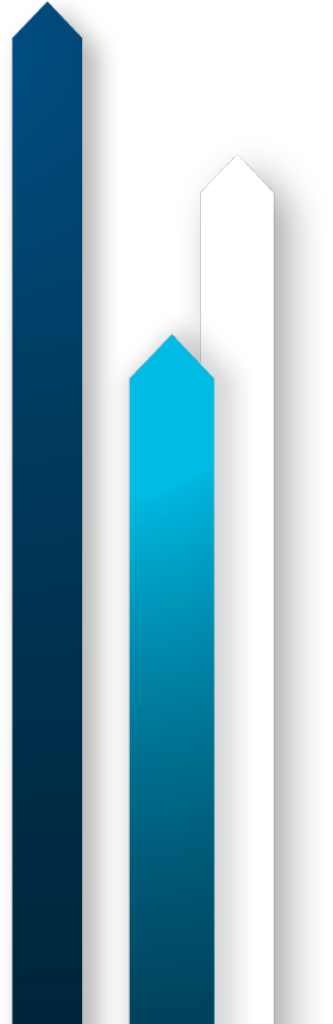
- The Stark law prohibits a physician from referring Medicare patients for designated health services (DHS) to an entity the physician (or immediate family member) has a financial interest in unless an exception applies.
- Many physician practices rely upon Stark's in-office ancillary services exception to comply with the Stark law.
- To meet the in-office ancillary service exception, a practice must qualify as a "group practice".
- Group practice qualifications include, but are not limited to, how DHS profits are compliantly distributed. However, Group practices are free to distribute all non-Medicare revenues and/or profits in any manner they choose.



# What Changed About the Group Practice Exception?



- Overall, the new Stark Rule provides several clarifications on how groups may share DHS profits after January 1, 2022, including but not limited to:
  1. DHS profits, or profits derived from all the DHS (combined) or any group with at least 5 physicians in a group, should be distributed rather than distribution by DHS revenue.
  2. No “split pooling,” or distributing profits on a DHS-by-DHS basis, is allowed. Profits from all DHS must be aggregated before distribution. An example includes:
    - Before: 1 pod of 5+ MDs (Lab), 2nd pod of 5+ MDs (imaging), 3rd pod of 5+ MDs (drugs)
    - After: 1 or more pods (each with 5+ MDs) that each aggregate lab, imaging, and drugs
  3. Distribution methodology can differ among different pods. Example includes distribution on a per capita basis, personally performed services, etc.
  4. Profits from DHS that are directly attributable to a physician’s participation in a Value Based Enterprise is permissible.





# Advanced Practice Providers

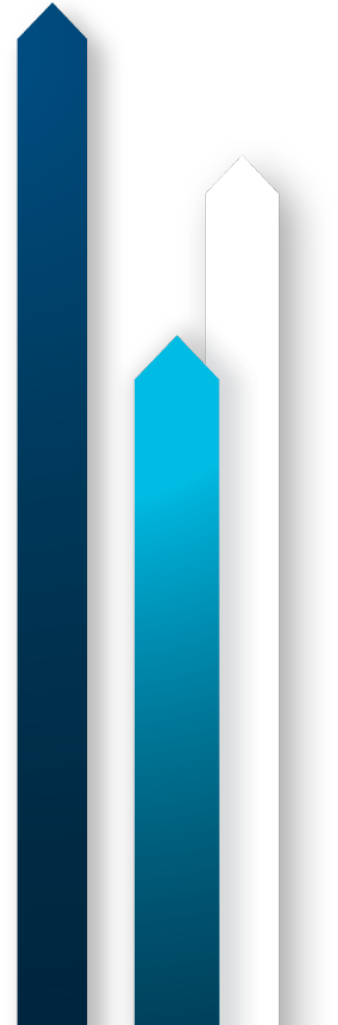
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# The Highlights



- In the 2022 Medicare Physician Fee Schedule Final Rule (Final Rule), the Centers for Medicare & Medicaid Services (CMS) announced new rules for split/shared visits in the facility setting.
- For 2022, such visits may be billed under the National Provider Identifier (NPI) of the physician or non-physician practitioner (NPP) who either:
  - Documents the support for the history, exam, or medical decision-making for the visit, or
  - Provides more than 50% of the service time.
- For 2023, split/shared visits must be billed under the NPI of the individual who provides more than 50% of total visit time.

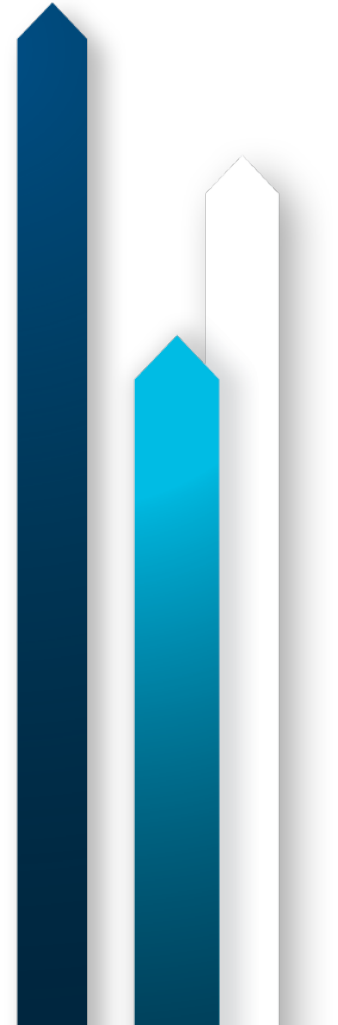




# The Changes



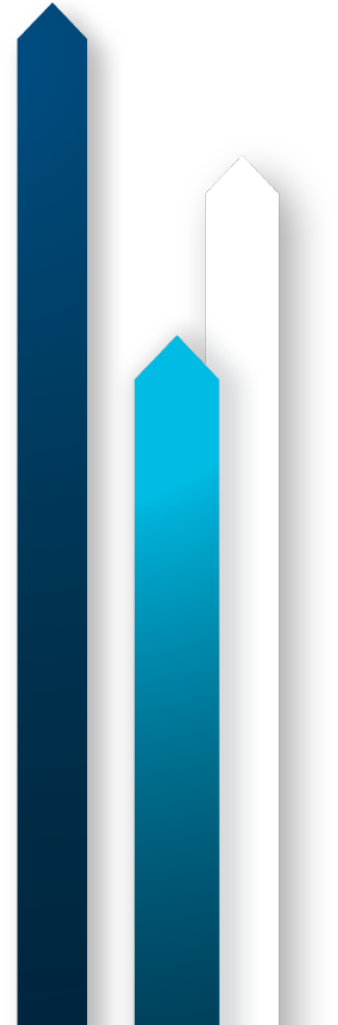
- The split/shared visit rules do not apply to office visits (place of service 11); instead, these visits may be billed ‘incident to’ if the requirements are satisfied (established patient, established plan of care/condition, direct supervision). CMS has signaled that it will be reviewing the incident to rules in future rulemaking.
- CMS now will permit split/shared visits to be reported for new patients as well as established patients, for initial as well as subsequent visits, for critical care services, for prolonged E/M visits, and for skilled nursing facility/nursing facility E/M visits (other than those required to be performed in their entirety by a physician).
- CMS will require the use of a new modifier (yet to be identified) to identify all claims for split/shared visits.
- Documentation in the medical record must identify the two individuals (physician and NPP) who performed the visit.



# The Changes... Continued

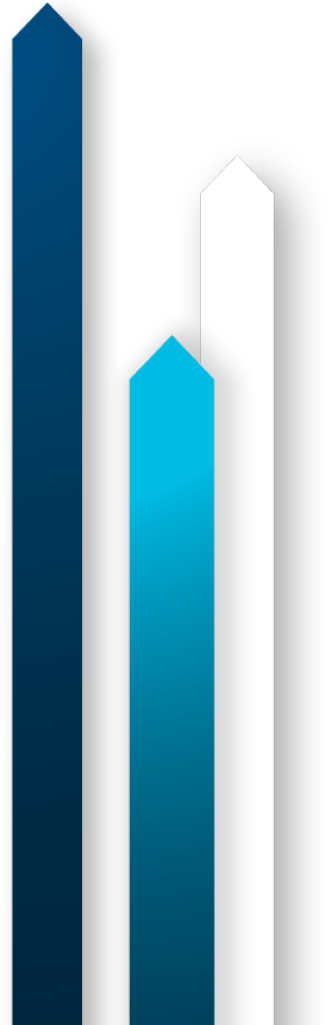


- **A split/shared visit must be billed under the NPI of the individual who performed the substantive portion of the visit.** That individual also must sign and date the medical record
  - For 2022 only, split/shared visits may be billed under the physician's NPI if
    - The medical record documentation indicates the physician performed one of the three key components (history, exam, or medical decision-making) in its entirety, or
    - More than half of the total time for the visit was spent by the physician. Otherwise, the visit must be billed under the NPP's NPI. (For critical care services, only time may be used.)
  - Beginning in 2023, only time will be used to determine the substantive portion of the visit.



## Compliance Tips

- Only apply these rules to Medicare claims reporting. Monitor other payers for their split/shared visit requirements, which are usually a part of the payer's incident to policy.
- Review physician and NPP contracts for potential impacts to compensation as the billing for these services will likely shift to the NPP. Work relative value unit (wRVU) capture for these providers will likely be different from what was anticipated during the compensation design.
- Ensure Medicare enrollment for NPPs is active and accurate.
- Monitor Medicare Administrative Contractor guidance on the application of this new policy.
- Evaluate physician compensation plans (where applicable) as these plans likely do not currently anticipate the split/shared visit rule changes.
- CMS has provided a one-year transition period, but this flexibility will end effective January 1, 2023.



**Thank you!**



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