The Rules of the Code

For hospital-based E/M codes, less is more in 2023 (or is it?)

By Kelsi O'Brien, MHSA

The RVS Update Committee (RUC) has continued its work in 2023, with sweeping changes beyond the outpatient E/M code sets and significant changes to E/M codes utilized in other care settings such as nursing facilities and inpatient care. If you have not read our previous article titled "The Primary Care Compensation Paradigm Shift That Was Meant to Be," we recommend you start there to understand the history of the RUC as the architect of the most recent changes. Their goals are clear and their intentions good, but time will tell if these changes have the intended impact.

Let us start by breaking down the changes that went into effect on January 1, 2023. For the purposes of this article, we will focus on changes impacting hospital inpatient and consultation care, including the deletions, substitutions, and value changes (Figure 1).

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Figure 1

Changes Impacting Hospital Inpatient and Consultation Care

Deleted Codes	2022 Work RVUs	Substitute Codes	2023 Work RVUs	Work RVU % Change	Deleted Descriptions	Substitute Descriptions
99217	1.28	99238	1.5	17%	Observation care discharge	Hospital discharge day (≤30 min)
99218	1.92	99221	1.63	-15%	Initial observation care	Initial hospital care (≥40 min)
99219	2.6	99222	2.6	0%	Initial observation care	Initial hospital care (≥55 min)
99220	3.56	99223	3.5	-2%	Initial observation care	Initial hospital care (≥75 min)
99224	0.76	99231	1	32%	Subsequent observation care	Subsequent hospital care (≥25 min)
99225	1.39	99232	1.59	14%	Subsequent observation care	Subsequent hospital care (≥35 min)
99226	2	99233	2.4	20%	Subsequent observation care	Subsequent hospital care (≥50 min)
99241	0.64	99242	1.08	69%	Office consultation	Office consultation (≥20 min)
99251	1	99252	1.5	50%	Inpatient consultation	Inpatient consultation (≥35 min)

Despite the historical events related to the outpatient E/M codes, medical groups are in unprecedented territory yet again. The latest set of code changes saw not only work RVU (wRVU) increases, but also more notable actual decreases (Figure 2). It was undeniable in the outpatient setting that wRVUs and reimbursement would increase with the weight changes, but that is not necessarily the case this time around.

Medical group expenses continue to increase as costs—especially provider and clinic staff compensation—are up overall. Provider compensation increased 3%–5% across the various specialties in 2022 despite the decision by the Centers for Medicare and Medicaid Services (CMS) to decrease reimbursement per wRVU for the third year in a row. There are two important areas that medical groups should forecast when anticipating the impact of these changes: provider compensation and revenue.

Compensation Increases or Decreases

When forecasting the impact of the changes, you may be tempted to overlook the compensation impact, as shift-based specialties are traditionally compensated based on a fixed shift or hourly rate without a productivity (wRVU) component. However, when you dive into the specialties that bill the codes outlined, there are areas impacted on productivity-based compensation plans.

Cardiology and Infectious Disease are two key examples. We conducted two case studies on inpatient rounding and consultation services to better understand the impact of the changes at the specialty level (Figure 3). The results outline the top eight specialties and the projected increase in compensation from the weight changes. While some of these

Figure 2

Latest Code Changes

CPT	Description	2022 Work RVUs	2023 Work RVUs	Work RVU % Change
99221	Initial hospital care	1.92	1.63	-15%
99222	Initial hospital care	2.61	2.6	0%
99223	Initial hospital care	3.86	3.5	-9%
99231	Subsequent hospital care	0.76	1	32%
99232	Subsequent hospital care	1.39	1.59	14%
99233	Subsequent hospital care	2	2.4	20%
99234	Observ/hosp same date	2.56	2	-22%
99235	Observ/hosp same date	3.24	3.24	0%
99236	Observ/hosp same date	4.2	4.3	2%
99238	Hospital discharge day	1.28	1.5	17%
99239	Hospital discharge day	1.9	2.15	13%

Figure 3

Impact of Code Changes at the Specialty Level

Case Study #1 500+ Providers 12 Hospitals, Not-for-Profit System		
Specialty No.	Specialty name	% Compensation Change
1185	Hospitalist – Internal Medicine	10.70%
1441	Psychiatry – Inpatient	6.45%
1200	Infectious Disease	6.09%
1430	Physical Medicine and Rehabilitation	5.46%
1317	Palliative Care	3.41%
1451	Pulmonary Disease (With Critical Care)	2.85%
1010	Cardiology – Invasive Interventional	2.54%
1020	Cardiology – Echo Lab and Nuclear	2.35%

Case Study #2 1,300+ Providers 7 Hospitals, Not-for-Profit System		
Specialty No.	Specialty name	% Compensation Change
1150	Geriatrics	7.03%
1186	Hospitalist – Family Medicine	6.77%
1200	Infectious Disease	6.46%
1440	Psychiatry	4.42%
1317	Palliative Care	3.24%
3185	Physician Assistant – Surgical	3.23%
1450	Pulmonary Disease (Without Critical Care)	3.05%
3113	Nurse Practitioner – Medical Specialty	2.26%

specialties are to be expected, others may not have been on your radar.

Each case study had only one specialty show a decrease of greater than 1% in compensation, those being nocturnists at –7.1% and hematologists/oncologists at –1.5%. In the analysis, if a deleted code with a substitution was billed, we assumed the new code would qualify. There could also be additional unpredictable changes with code distributions given the documentation requirements for the codes in question have changed.

Unfortunately, we will not know the impact this latest round of changes has on the market data until the summer of 2024, as current survey data always reflect the previous calendar year. Medical groups must realize that they could be paying exponentially higher compensation to physicians and providers within the noted specialties during this lag. While that does not mean there is not a case for allowing the compensation to increase, affordability must be considered.

Revenue in the Red or Black

In case study #1, the projected changes would have resulted in an additional 80,325 wRVUs or 2.2% more wRVUs overall. At the existing CMS conversion factor of $33.89, that is an additional $2.7 million in revenue. In case study #2, the changes resulted in 70,200 additional wRVUs or 1.8% more overall, which signifies an additional $2.4 million in reimbursement under CMS.

Utilizing the CMS conversion factor for the projections is a conservative approach, and considerations should be made for your own group's payer mix. Certainly, the complement of specialties and the size and scope of the inpatient work are also factors, but it is reassuring to know that the impact is trending positive.

The New Normal

As we continue to see hallmark changes to E/M services across the board regardless of care setting, CMS have noted that they hope to reduce administrative burden with many of the changes. The latest round of adjustments acknowledged that professional billing was overly complicated by having separate codes for observation versus inpatient status patients. Providers can focus less on the admission status of the patient and more on providing the right care. One sentiment noted in the committee is that it was about "putting patients over paperwork." Only time will tell if that goal has truly been achieved, but an immediate positive is additional revenue for medical groups.

It is undeniable that more wRVUs are being generated than ever before, but not necessarily because volume has increased. Medical groups need to keep an eye on their financials, as this potentially means adding both expense and revenue. The specific impact will vary based on a number of factors, but as the market normalizes, we hope this will be a positive change for medical groups and providers. GPJ

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