RVU PRIMER FOR MIDWIVES: THE 2023 UPDATE

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[Update to Jan 2021 webinar]

Grow Midwives

Scaling Up and Sustaining Midwifery

Disclosures

- I have no experience as a certified coder or biller.
- I have researched the subject matter in-depth but do not claim to be an expert.
- Information presented is based on research and consulting services.
- Contracts presented are real and redacted for confidentiality.

Friend or Foe: Continuing Facts

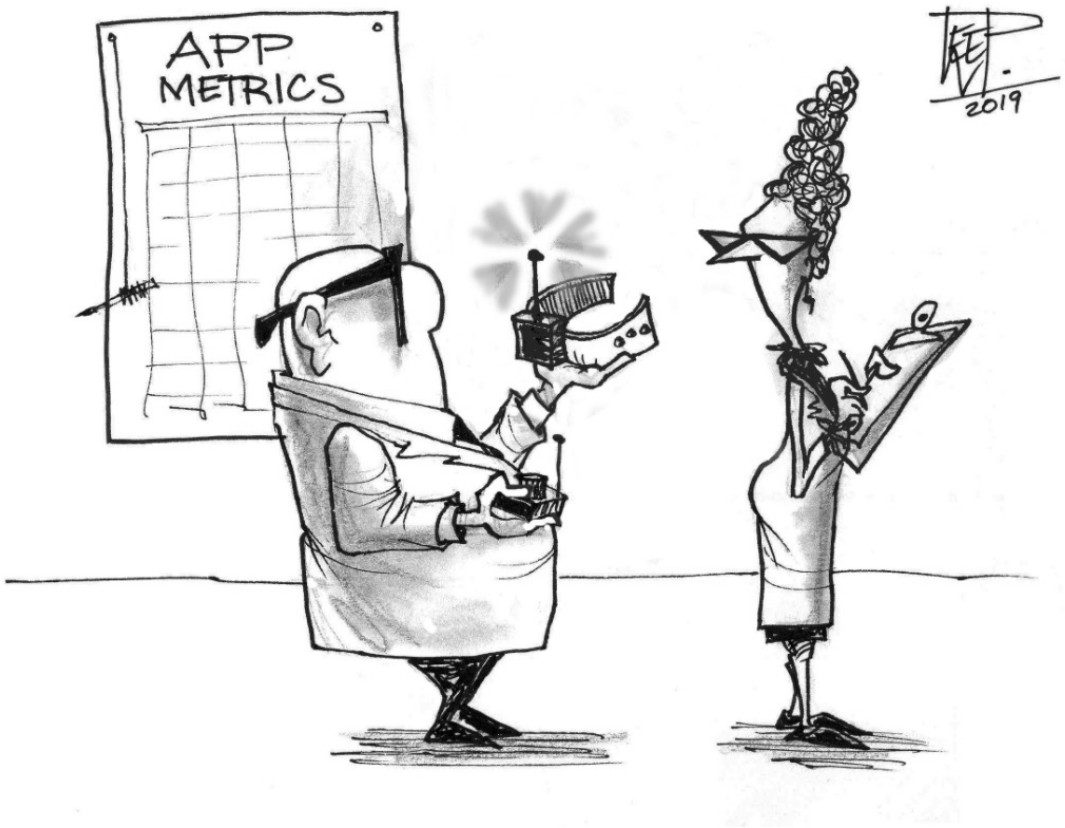
ZERO published research discussing RVU compensation for *Midwifery Profession*

RVUs are **designed for Physician practice** not Advanced Practice Providers (APP)

Billing 'Incident To', Split or Shared visits complicates RVUs tracking and often misclassifies work

If RVUs do not differentiate provider type/CPT code, then why are **APPs not benefited by the same WORK value**?

What are they and how were they formulated?



What is a Relative Value Unit (RVU)?

- In 1992, **Medicare** changed **physician payments.** They worked with AMA to create a standardized fee schedule based on RVUs and CPT coding.
- The dollar amount is determined by calculating the: **physician's work**, **practice expenses**, and **malpractice insurance**.
- Physician Work is divided into 4 subcomponents (wRVU):
  1. Time it takes to perform the service
  2. Technical skill and/or physical effort required to perform the service
  3. Amount of mental effort and judgment required
  4. Stress arising from any potential risk to the patient from performing the service

Do RVUs only drive Medicare Reimbursement?

- NO - The reimbursement impact of RVU system is not limited to Medicare.
- Virtually every commercial carrier benchmarks its fee schedule to the Medicare fee schedule.
- Overall, commercial plans reimbursement has always been higher than what Medicare pays.
  - Private insurers' payment rates are determined through negotiations with providers and vary depending on market conditions e.g., the bargaining power of individual providers relative to insurers in a community

https://healthcostinstitute.org/hcci-research/comparing-commercial-and-medicare-professional-service-prices

Payment Basics

- RVUs are derived from the billing process. **RVUs are assigned to a CPT code** to determine reimbursements.
  - CPT and ICD codes create a full picture of the medical process for the payer. “This patient arrived with *these* symptoms (as represented by the ICD code) and we performed *these* procedures (represented by the CPT code).
- RVUs do not change based on provider rendering the service.
- RVUs are based on the level of difficulty of a procedure or level/acuity of the patient evaluation.

The more complex a patient interaction is, the more wRVUs assigned!

RVU Salary and/or Incentive Pay

- Most physicians, and **some APPs** must attain “X” RVUs to achieve their baseline salary and/or measured for bonus compensation.
- Employers use national directories to determine the average number of RVUs by %tiles performed **by physician types,** in each **specialty,** and **each region** of country.
  - These directories are based on **surveys of institutions that employ physicians**
  - The most prominent and oldest national directory is Medical Group Management Association (MGMA)
  - *MGMA projects %tiles for all APP roles, however NO metrics are formulated in any consistent methodology for RVU expectations*
  - RVUs are NOT allocated to time spent for patient education, coordinating referrals, or **any** non billable service.

Physician wRVUs by Specialty – Dec 2022

Physicians report the highest median wRVUs:

- Cardiovascular surgeons: 9,822
- Neurological surgeons: 9,333
- Radiologists: 8,862
- Ophthalmologists: 8,438
- Orthopedic surgeons: 8,009
- Urologists: 7,364
- Cardiologists: 7,336

Physicians with the lowest median wRVUs:

- Psychiatrists: 3,689
- Oncologists: 4,198
- Rheumatologists: 4,401

https://physiciansthrive.com/wrvu-physician-compensation/

Additional MGMA data (22)

Specialty	Median Compensation[1]		Median wRVU Productivity[1]	
	Urban	Rural	Urban	Rural
Family Medicine (without OB)	$268,880	$269,473	5,208	4,704
General Surgery	$456,878	$424,366	6,819	5,766
Orthopedic Surgery	$667,507	$591,610	9,220	7,127
Pediatrics	$236,391	$246,928	4,708	4,769
Urology	$524,353	$507,877		

[1]Per the Medical Group Management Association ("MGMA") *2022 DataDive Provider Compensation Survey.*

OB/GYN RVUs

Q: Does the RVU model of benefit the OB/GYN?

National Median RVUs = 6,956/year

A: *Depends on how/where employed and compensated*

(Citation next slide)

MGMA Productivity

	10th %	Median	90th %
Obstetrics/Gynecology: General	3,084	6,956	11,462
OB/GYN: Gynecology (Only)	2,051	4,873	8,950
OB/GYN: Gynecological Oncology	3,352	6,419	12,965
OB/GYN: Maternal and Fetal Medicine	4,898	8,834	16,782
OB/GYN: Reproductive Endocrinology	1,950	4,553	10,771
OB/GYN: Urogynecology	2,108	6,025	8,399

(Slide from Dr's Gecsi and Ogburn, Business of Academic Medicine. Univ TX, Rio Grande Valley, Presentation https://sasgog.memberclicks.net/assets/docs/1010%20am,%20Bus%20of%20Medicine,%20Gecsi,%20Ogburn.pdf. 2018)

What is the Conversion Factor (CF)

- The CF is the multiplier that Medicare applies to RVUs to calculate reimbursement
- Jan 2023 CMS announced a new CF rate
  - The CF for 2023 is $33.88
  - 2.5% positive adjustment from prior year
  - In 1992 when RVU model began the CF was $31.00
- Commercial insurance companies establish their own rules, regulations, bundles, fee schedules, and global fee for procedures.

Ex: Total Laparoscopic Hysterectomy

In 2018 the RVU 13.36 x $35.99 (CF) = $480.82

In 2023 the RVU 13.36 x $33.88 (CF) = $452.00 (Medicare)

vs. $678 (Private @ 1.5x Medicare rate)

Decrease Medicare Reimbursement Dollars

Physician Salary based on RVU Production Only

- Surgeon typically paid at $60.00 per wRVU. If produces 6,000 wRVUs/year compensated $360,000
- Primary care physician specialties annual volume are around to 3,000-4,000 wRVUs at avg $46.00/ RVUs per year = $184,000
- Midwife contracts we reviewed stipulated:
  - Salary paid at $16 per wRVU at target of 5,000/year
  - Compensation = $80,000
  - *Do you know how hard you would have to work to achieve 5,000 RVUs? Not likely!*

OB v. Midwife RVUs
What is reasonable benchmark?

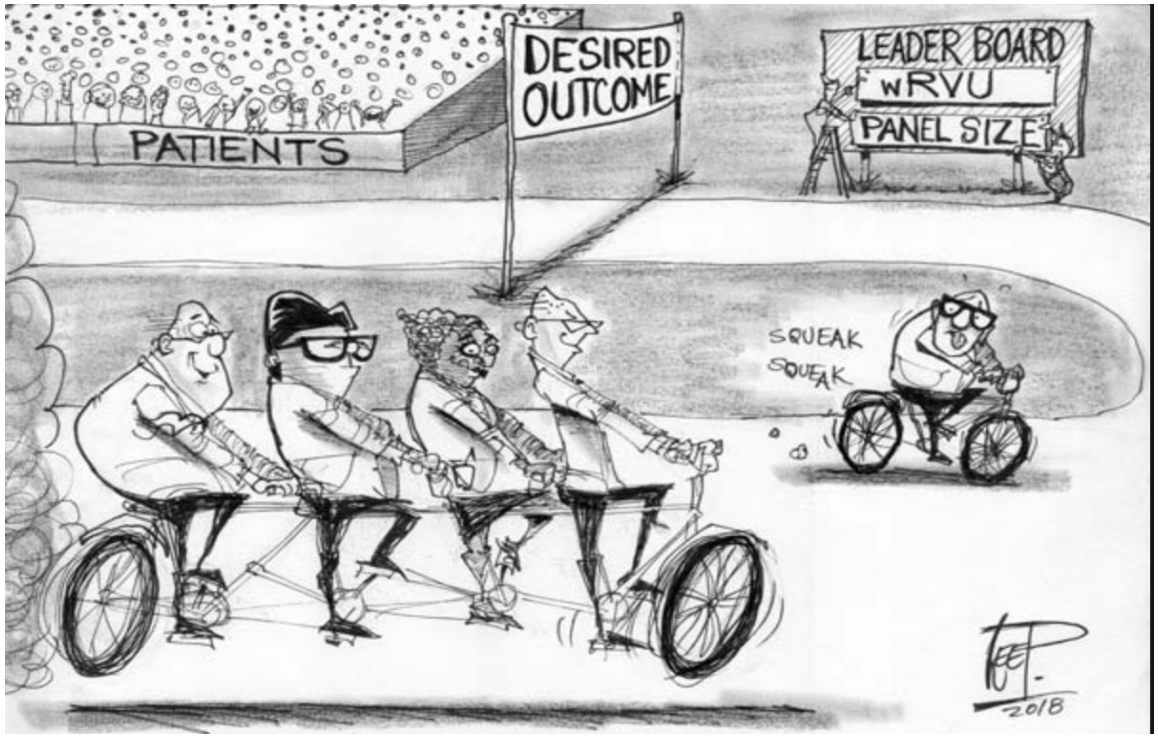
Avg RVUs by OB/GYN in group 6596/year

OB/GYN - 200 working days year @6596 RVUs/Year =

33 RVUs/day

[252 working days/year
Difference is weekends, away time, administrative work]

What should be avg RVUs Midwife day/year?


PATIENTS
DESIRED OUTCOME
LEADER BOARD
wRVU
PANEL SIZE
SQUEAK
SQUEAK
2018

No Clue!

Why? Confounding variables for APPs

Incident-to billing (now even stricter CMS rules in ‘23)

Shared visit billing

Global billing

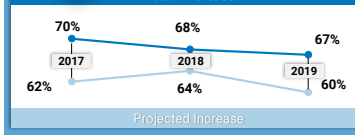
Coding by billing provider instead of rendering provider

Formula was not designed for APPs

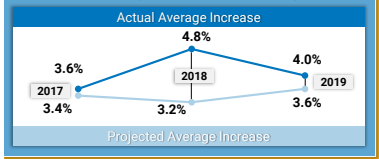
2019 Advanced Practice Provider Compensation and Pay Practices Survey

Demand for APPs continues to outpace expectations in select specialties and locations - creating upward pressure on compensation for these providers

Percentage of Organizations Increasing the Number of APPs



Percentage Increase in Base Pay



APP leadership positions and structures play an increasingly important role in the effective utilization and management of APPs

58% of responding organizations have designated APP leaders

APP Leaders by Level
2019 Prevalence

Clinical-Level	79%
Middle-Level	54%
Top Leader	26%

Clinical integration between APPs and physicians can be accelerated through aligned reward strategies that improve provider engagement

Actual Median APP Incentive Amounts
(Three-year straight average, 2017-2019)

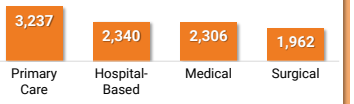
Primary Care	$7,444
Medical	$5,753
Surgical	$5,542
Hospital-Based	$5,503

32% of APP incentive programs contain a team-based component

More organizations are collecting and reporting APP productivity data

NP/PA Median wRVUs
(Three-year straight average, 2017-2019)

66% Increase in Incumbents



Ongoing challenges to recruiting and retaining top APP talent will require a focus on competitive compensation and engagement strategies

APP Recruitment and Retention Practices
2019 Prevalence

Sign-On Bonus	Relocation Assistance	Retention Bonus
87%	75%	49%

Source: SullivanCotter 2017-2019 *Advanced Practice Provider Compensation and Pay Practices Survey Report*

SullivanCotter

2020 Survey Open for Participation
Learn More

Contact-Us@sullivancotter.com

Common Code – 99385 (Annual exam 18-39 years old)

- RVUs for 1 Exam CPT 99385 = 1.92 wRVUs
  - For average range OB/GYN needs 33 wRVUs/day that means ~ 17 routine normal exams/workday

Key Questions:

- Is work volume expected to be equivalent to an OB/GYN?
- What if midwife did all the normal annual exams?
- Who gets RVUs for global maternity care?
- What RVUs are shared or become ‘incident to’ in combined groups?

Potential Advantages of RVUs

- Could bonus on equivalent RVU (does not account for provider type)
- Encourages provider to have steady stream of patients
- Causes competition to get more new patients
- Encourages provider to be more PRODUCTIVE, likely to see more patients and perform more evaluations and procedures
- Paid on code submitted -- not codes collected and paid for
- Not affected by differential in insurance payments

Disadvantages of RVUs for APPs

- Only RVUs based comp/salary, leads to practitioners burning out and leaving
- Some RVUs paid on sliding scale, ramping up competition among team
- RVUs do not pay for everything you do –
  - Mentoring, Admin Time, Teaching, Meetings, Tasks outside care
  - Less likely to refer patients and more likely to compete for new patients
- Paid for volume of care not QUALITY of care
- ALL Bundled or Global procedures pay less
- Modifiers can create less RVU value
- INCORRECT codes or under coding will contribute to under performing

Pitfalls for Midwife RVU comp

- If not recognized as a billing provider and all services billed to physician name or practice – where do RVUs go?
  - Physicians then assigned your RVUs
- Work attributed to billing 'Incident To'
  - Midwife direct reimbursement is less as billed under physician and can't track
- Midwife services often bundled (OB) Much work not attributed to RVU
  - Triage, Care Coordination, Labor Support, On-Call Services, Post Op Rounding, Shared Visits
- Disproportionate time between ambulatory and hospital setting
  - More time in hospital = Less time seeing ambulatory office patients = (<) RVUs
- CPT codes Midwives use are not as complex or procedural based.
  - OB care is global fee
  - Longer patient visits
  - E&M codes have lower RVUs than CPT codes

Midwifery Contracts 2022-23

- **<u>Required</u> minimum was to accrue**
  3,500 RVUs/year, No CF listed
- No repercussions outlined in agreement if not achieved
- Minimum work expectations 48 hours/week
- Offered Salary of $89,000
  - Hourly Salary = $35.66

Consider pro/cons

- Straight 40-hour work week
- Incentive Bonus based on wRVUs Benchmark of 1,900 in first year of employment
- All wRVUs attained above the benchmark paid at $35 per wRVU.
- Salary $107,000

Model NOT based on a Conversion Factor

ANNUAL NUMBER OF BILLABLE wRVUs	BONUS
2,160 – 2,279	$800
2,280 – 2,399	$1,600
2,400 – 2,520	$2,400
2,521 – 2,640	$3,200
2,641 – 2,760	$4,000
2,761 – 2,880	$4,800
2,881 – 3,000	$5,600
3,001 – 3,120	$6,400
3,121 and greater	$8,000

Seriously!!

Base Compensation:	$100,000
Guarantee Period:	**Term of Agreement**
WRVU Conversion Factor (Incentive):	**$13.50**
Annual WRVU Productivity Target:	**3744**

Excessive descriptors...

Gross charges billed shall be credited to Employee's production at the time of service for the following CPT codes: 10060 thru 59320, 59409, 59412, 59414, 59514, 59612, 59620, 59812 thru 76856, 99201 thru 99397, 0502F, G0101 and Q0091. Gross charges for CPT code 58558, 58563, 59812, 59820 and any other CPT code in the foregoing list that include a medical device as part of the code shall be reduced by 125% of the cost to the Corporation of the device. Gross charges billed under Employee's name for CPT global OB prenatal codes 59425 and 59426 will not be credited to Employee as Employee is receiving credit for the individual prenatal visits. Employee shall receive credit equivalent to CPT code 59409 for any global OB delivery codes (e.g. 59400, 59410, 59610) billed under their name as Employee is receiving credit for the individual prenatal and postpartum care visits. Gross charges for all CPT codes will be adjusted as appropriate for place of service and any modifiers for multiple procedures, assistant surgeon, etc. Employee will receive no production credit for charges billed for supplies, immunizations, immunization/drug administration, drugs, IUDs, implantable contraceptives, medical devices, etc. Employee will be credited $105 for each OB visit (CPT 0502F) Employee performs that is billed as part of a global OB fee under the name of another provider and is not billed as a separate office visit under Employee's name.

Tiered Model

Productivity Bonus. Provider will be eligible for additional productivity bonus compensation based on the total work RVUs (**"wRVUs"**) generated personally by Provider. All wRVUs will be valued at rates annually established by the Compensation Committee. The current wRVUs value is **Thirty-Two Dollars ($32) per wRVU.**

If Provider's year-to-date ("**YTD**") compensation calculated using wRVUs and the earning rate per wRVU exceeds the sum of Provider's YTD salary plus any prior productivity bonus payments for the calendar year, the difference or surplus will be paid to Provider as follows:	70% of eligible YTD production surplus
Quarter 1:	
Quarter 2:	80% of eligible YTD production surplus, less amounts previously paid
Quarter 3:	90% of eligible YTD production surplus, less amounts previously paid
Quarter 4:	100% of eligible YTD production surplus, less amounts previously paid

What can Midwives do?

- Understand language and **ASK questions:**
  - What is CF, if not written in contract
  - Is there a difference between Physician and APP benchmark and CF
  - Is any non billable time tracked, valued and/or compensated
  - Request data that used that set the RVUs method outlined
  - What is avg RVU generated by Physicians and Midwives
  - What happens if you don't meet the benchmark
- Get to know Office staff coders, self audit and request monthly reports
- Understand how politics play in productivity measurement
- Keep log of all non-billables that adds value
- Consider Midwives pool RVUs and team bonus rather than provider competition

Other Types of Compensation Models

- **NET COLLECTIONS** more widely used and sometimes referred to as net production. It is **the actual cash received for services rendered.**
  - In many practices, cash received is recorded as the actual revenue, so this method is directly tied to the bottom line.
- Determine what a fair % of net collections above expenses can be counted out as a bonus (beyond base salary)
  - Generate $200,000 profit margin after expenses
  - Take home after costs set @ 10% = $20,000 bonus
- Need to be able to demonstrate financial value via proforma
  - Proforma would be net collections over expenses for 1 FTE Midwife

Conflating RVUs & Revenue Generation

Maternity Care 8 births/month (96/year) using CPT 59400

- **wRVUs** calculated
  - 36.58 RVUs attributed to global maternity care
  - 96 births/year = Total RVUs 3511/year
  - **CF 32.41 x 3511 = $113,791 allocated for about 100 births/year**
  - Private pay (CF 1.5xMedicare) = $170,720

- **Net Collections** for blended Commercial/Medicaid assuming average net $3,000/birth:
  - **$3,000/birth x 96 = $288,000 for same**

  [Remember, Medicaid pays about half of Commercial reimbursement]

Challenge of determining RVU revenue generation over Net Collections

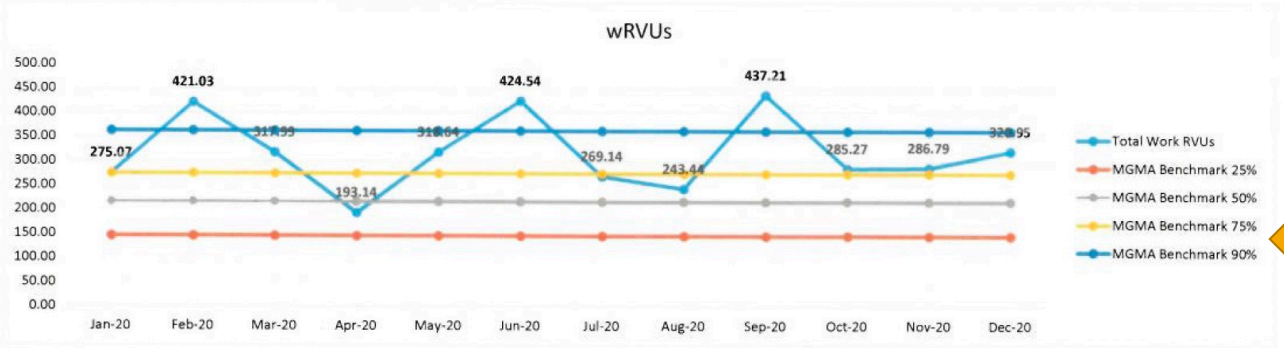
- Need to calculate each CPT code might bill for
- Know employers CF assigned to the Midwife
- Are they including procedures such as first assist, emergency department, ultrasounds and moderate to complex patients
- Billing appropriately if Shared Care or Incident to based on:
  - State Regulations and/or Hospital Bylaws pertaining to supervision
- **Two Examples**: 3 CNM full scope practice employed by OB/GYN Group and 10 CNMs employed within a MFM division of an academic teaching center

MGMA Specialty: Nurse Midwife: Outpatient/Inpatient Deliveries
Clinic: Women's Center
FTE: 1.00

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20	Jul-20	Aug-20	Sep-20	Oct-20	Nov-20	Dec-20	2020 Total	Annualized	2019 Total
Charge Amount	$57,095	$94,531	$53,624	$56,584	$78,256	$86,710	$59,532	$53,494	$72,190	$71,894	$59,301	$66,400	$809,609	$809,609	$869,956
Budget Charge Amount	$116,067	$43,180	$61,734	$87,974	$69,561	$65,597	$46,567	$87,720	$68,524	$79,005	$56,787	$82,253	$864,968	$864,968	
Women's Center Charge Amount	$641,504	$867,316	$735,835	$535,445	$710,229	$961,481	$721,763	$742,685	#########	$922,797	$720,918	$855,015	$9,494,848	$9,494,848	$10,476,837
Non Delivery wRVUs	76.77	79.73	41.82	40.23	90.27	153.06	93.53	76.22	104.94	107.16	106.02	120.57	1,090.32	1,090.32	847.41
Prenatal wRVUs	115.00	115.00	157.58	112.56	112.56	209.92	112.56	115.00	202.61	115.00	112.56	137.51	1,617.84	1,617.84	2,545.70
Delivery wRVUs	83.30	226.30	118.58	40.35	115.81	61.57	63.05	52.23	129.67	63.12	68.21	62.87	1,085.03	1,085.03	1,391.98
Total Work RVUs	**275.07**	**421.03**	**317.99**	**193.14**	**318.64**	**424.54**	**269.14**	**243.44**	**437.21**	**285.27**	**286.79**	**320.95**	**3,793.19**	**3,793.19**	**4,785.09**
Budget Work RVUs	558.65	207.83	297.14	423.44	334.81	315.73	224.14	422.21	329.82	380.27	273.33	395.90	4,163.27		
MGMA Benchmark 25%	146.08	146.08	146.08	146.08	146.08	146.08	146.08	146.08	146.08	146.08	146.08	146.08	1,753.00	1,753.00	1,681.00
MGMA Benchmark 50%	216.33	216.33	216.33	216.33	216.33	216.33	216.33	216.33	216.33	216.33	216.33	216.33	2,596.00	2,596.00	2,517.00
MGMA Benchmark 75%	275.25	275.25	275.25	275.25	275.25	275.25	275.25	275.25	275.25	275.25	275.25	275.25	3,303.00	3,303.00	3,552.74
MGMA Benchmark 90%	362.67	362.67	362.67	362.67	362.67	362.67	362.67	362.67	362.67	362.67	362.67	362.67	4,352.00	4,352.00	4,287.66
Women's Center WorkRVUs	2,874.52	4,827.80	3,808.23	2,424.14	3,467.93	4,525.00	3,153.85	3,669.42	5,406.03	4,619.31	3,437.59	4,013.31	46,227.13	46,227.13	50,530.81
Clinic MGMA Benchmark 25%	2,768.78	2,768.78	2,768.78	2,768.78	2,768.78	2,768.78	2,768.78	2,768.78	2,768.78	2,768.78	2,768.78	2,768.78	33,225.30	33,225.30	34,952.90
Clinic MGMA Benchmark 50%	3,681.68	3,681.68	3,681.68	3,681.68	3,681.68	3,681.68	3,681.68	3,681.68	3,681.68	3,681.68	3,681.68	3,681.68	44,180.10	44,180.10	47,569.84
Clinic MGMA Benchmark 75%	4,640.50	4,640.50	4,640.50	4,640.50	4,640.50	4,640.50	4,640.50	4,640.50	4,640.50	4,640.50	4,640.50	4,640.50	55,686.00	55,686.00	62,188.96
Clinic MGMA Benchmark 90%	5,844.73	5,844.73	5,844.73	5,844.73	5,844.73	5,844.73	5,844.73	5,844.73	5,844.73	5,844.73	5,844.73	5,844.73	70,136.70	70,136.70	72,304.43
E&M Visits	131	127	101	79	142	166	167	107	137	137	120	147	1,561	1,561	1,528
Women's Center E&M Visits	1,251	1,121	1,166	902	1,368	1,456	1,422	1,404	1,438	1,348	1,167	1,431	15,474	15,474	15,104
Gross Revenue Per Encounter	$436	$744	$531	$716	$551	$522	$356	$500	$527	$525	$494	$452	$519	$519	$569
Approved Days Off Used															

2022: 3 CNMs we assisted to raise salaries

Negotiated to get 10% of net profit margin!!



10 CNMs scope is 95% OB services within MFM division (2022)

TOTAL	A -- 0 to 30 days	2,028,819.32	1,953,360.40	2,156,780.25	2,114,858.85	8,253,818.82	75.07%
	B -- 31 to 60 days	253,014.74	575,477.32	356,297.16	244,783.38	1,429,572.60	13.00%
	C -- 61 to 90 days	55,758.44	149,798.96	156,264.25	118,175.85	479,997.50	4.37%
	D -- 91 to 120 days	49,951.43	27,079.94	69,666.38	43,425.49	190,123.24	1.73%
	E -- 121 to 150 days	30,924.44	18,831.97	60,934.94	35,861.01	146,552.36	1.33%
	F -- 150 + days	61,639.72	38,129.64	111,195.43	284,513.80	495,478.59	4.51%
	N/A	0.00	0.00	0.00	0.00	0.00	0.00%
	AR Aging (days)	2,480,108.09	2,762,678.23	2,911,138.41	2,841,618.38	10,995,543.11	100.00%

Profit Margins for FTE Midwife in Full scope large, traditional practice (Not home or birth center)

- Use data on receivables on:
  - #births/month using average rate on blended case mix of payers
  - #annual (WW/GYN) exams/month
  - #additional billable procedures month
- After expenses [Salary, Malpractice, Benefits, using 30% Overhead] Midwives generate on average $250,000 – $350,000+ in profit/year on billable services.
- This does not count hospital facility fee where patient chose setting because of midwife-led care. This is a significant contributor to hospital bottom line.

What are other Incentive-based Compensation Models

- **Quality and Outcome Indicators**
  - % Readmission, Access, Discharge timing
  - Attend Committee/Quality Meetings (PQI, M&M, MMRC, FIMR, other)
  - Professional Contributions – Articles, Presentations, Teaching, Leadership Role
- **Patient Satisfaction**
  - Press-Ganey data or In-practice survey methods
- **Encounters/Experiences**
  - Set number of patients seen in day, or births/month, or c/section assists
  - Determine incentive targets, and if surpassed, XX paid out as bonus

Review of Midwifery Contracts have WIDE variance in:

- CF and wRVU benchmarks
- Base salary with or without incentive
- Defined work week (minimum/maximum hours)
- Pay for additional work
- Types of incentive models within one agreement

Our Conclusions:

No reliable data on Midwife RVU Comp Modeling

- MGMA - minimal rigor and reliability for midwifery as unique profession outside physician supervision, and they blend all the APP roles
- Sullivan-Cotter data (2019) uses input from 155 organizations representing only 1,000 Midwives and variety of employment models (Table2.2)

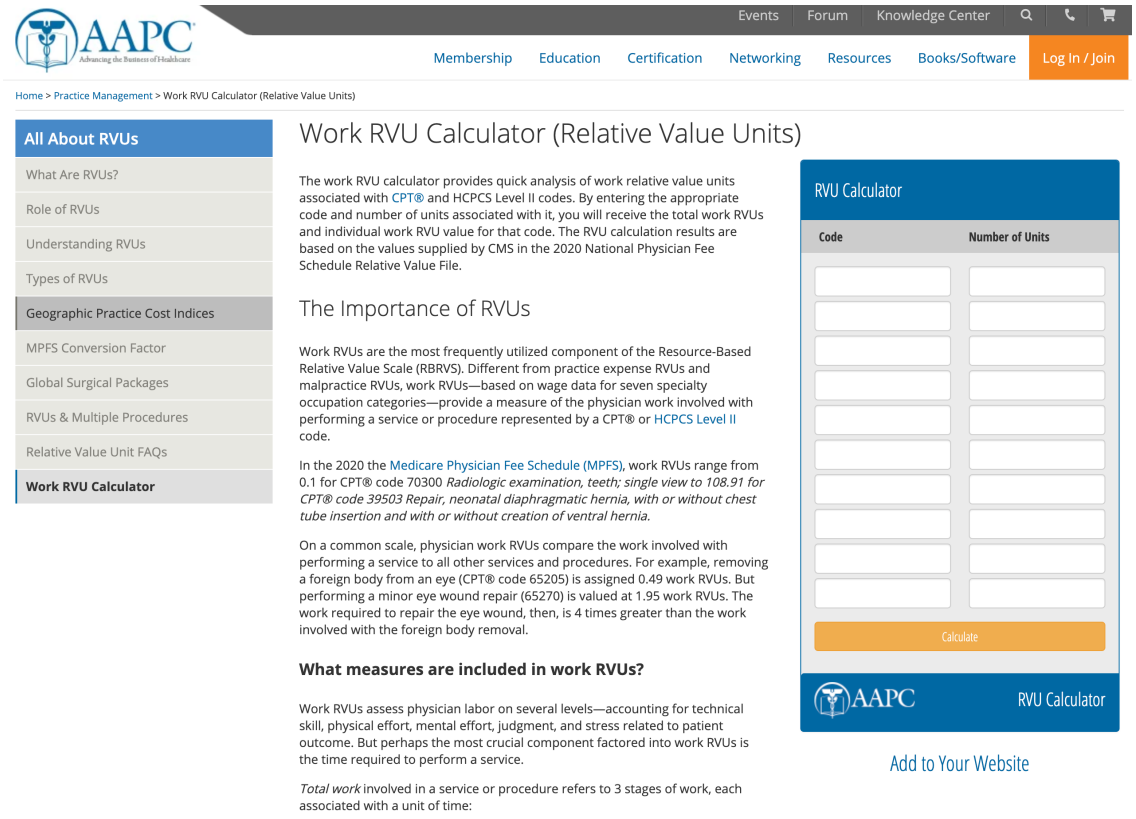
OWNERSHIP

TABLE 2.2 – Majority Ownership of Medical Group

Majority Ownership of Medical Group[1]	
Type	Percentage
Health System	47%
Physicians	30%
Hospital	9%
Physician Practice Management Company	4%
Insurance Company or Managed Care Organization	1%
University or Medical School	0%

In Order to Effectively Negotiate

- Understand the language and metrics described within the agreement
- Scheduling of new patients and types of ambulatory patients
- Assured adequate exam rooms, support staff and number of office days
- Does RVU model instill competition with other midwives and/or physicians
- Are more complex visits or caring for more patients in a day part of the value and outcomes Midwives provide
- Ask self - *How hard as well as HOW do you want to work*



FREE Searchable Medicare Physician Fee Schedule

Find All RVUs by CPT code

https://www.aapc.com/practice-management/rvu-calculator.aspx

ACOG Intro to NEW 2023 E/M Changes

https://www.acog.org/practice-management/coding/physician-payment/medicare-physician-fee-schedule

Medicare Physician Fee Schedule

Read and review summaries of the direct impacts of recent Medicare Physician Fee Schedule (MPFS) rules on obstetrician-gynecologists' practices.

Share | Print

Practice Management

- Coding
- Physician Payment
  - Medicare Physician Fee Schedule

back

2023 Medicare Physician Fee Schedule

The calendar year (CY) 2023 Medicare Physician Fee Schedule (PFS) final rule is one of several rules that reflect a broader Administration-wide strategy to create a more equitable health care system that results in better accessibility, quality, affordability, and innovation. Released by the Centers for Medicare and Medicaid Services (CMS) annually, updates the standards for physician reimbursement and policies related to the delivery of health care. While the fee schedule and regulations are for services for Medicare beneficiaries, Medicaid programs and private insurers utilize them as standards for their own payment rates and coverage policies.

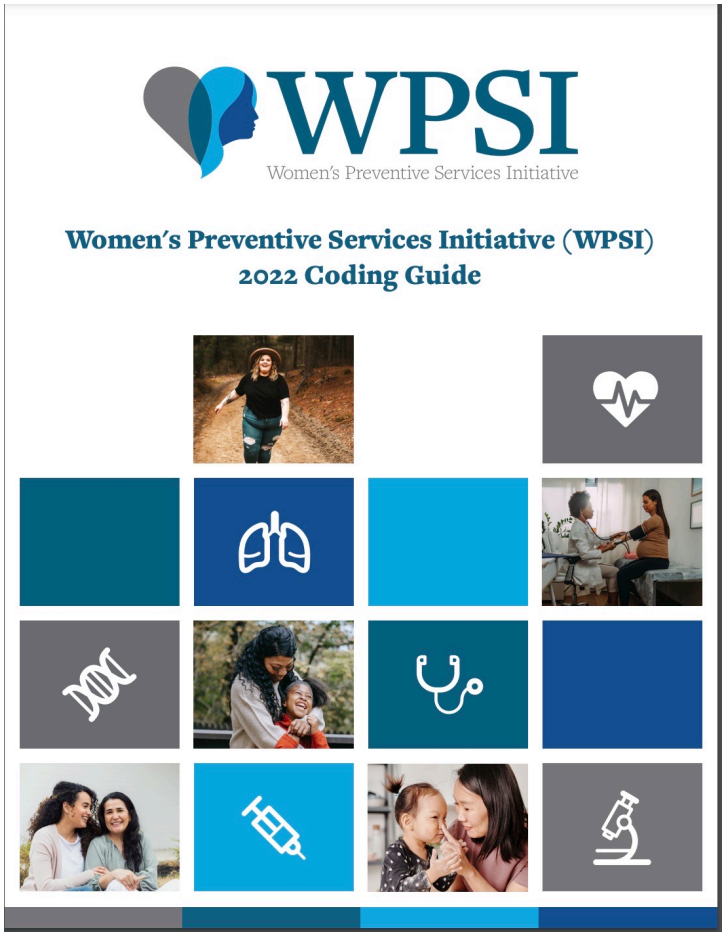
Calendar Year 2023

PFS Rate-Setting and Conversion Factor

CMS is finalizing a series of standard technical proposals involving practice expenses, including the implementation of the second year of the clinical labor pricing update. With the budget neutrality adjustments, which are required by law to ensure payment rates for individual services don't result in changes to estimated Medicare spending, and the expiration of 3% supplemental increase to PFS payments for CY 2022, the final CY 2023 PFS conversion factor is $33.89, a decrease of $0.72 to the CY 2022 PFS conversion factor of $34.61. This reflects action taken by Congress in December 2022 to mitigate the cuts initially set in the 2023 Medicare Physician Fee Schedule.

Comprehensive Codes for Women's Health

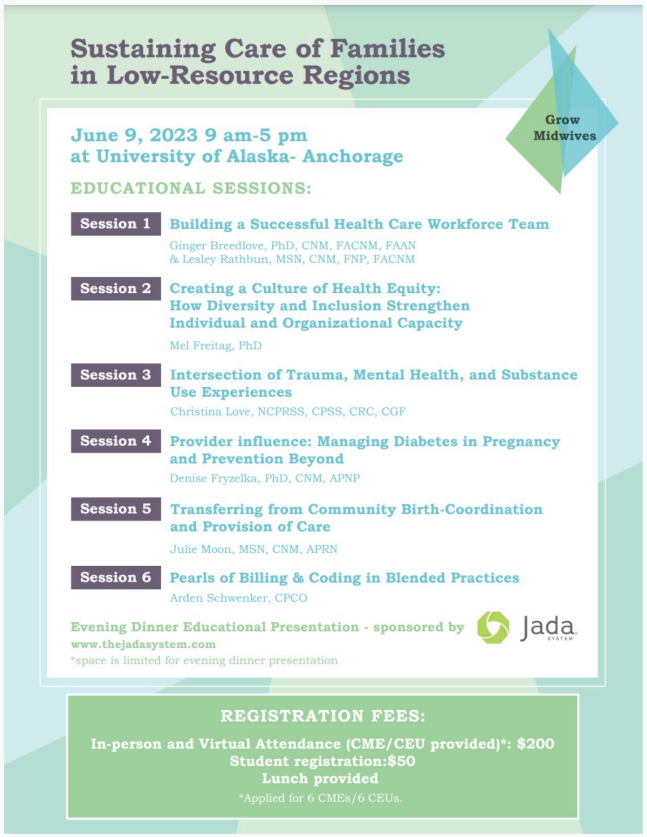
https://www.womenspreventivehealth.org/wp-content/uploads/FINAL_WPSI_CodingGuide_2022_Pages.pdf



Sage advice

Need to understand the value of numbers in order to negotiate your worth~

Alaska Conference in person OR virtual



June 9. 2023 9 AM - 5 PM
University Of Alaska - Anchorage

Educational sessions:

- Session 1: Building a Successful Health Care Workforce Team

- Ginger Breedlove PhD, CNM, FACNM, FAAN & Lesley Rathbun, MSN, CNM, FNP, FACNM

- Session 2: Creating a Culture of Health Equity: How Diversity and Inclusion Strengthen Individual and Organizational Capacity

- Mel Freitag, PhD

- Session 3: Intersection of Trauma, Mental Health, and Substance Use Experiences

- Christina Love, NCPRSS, CPSS, CRC, CGF

- Session 4 Provider Influence: Managing Diabetes in Pregnancy and Prevention Beyond

- Denise Fryzelka, PhD, CNM, APNP

- Session 5 Transferring from Community Birth-Coordination and Provision of Care

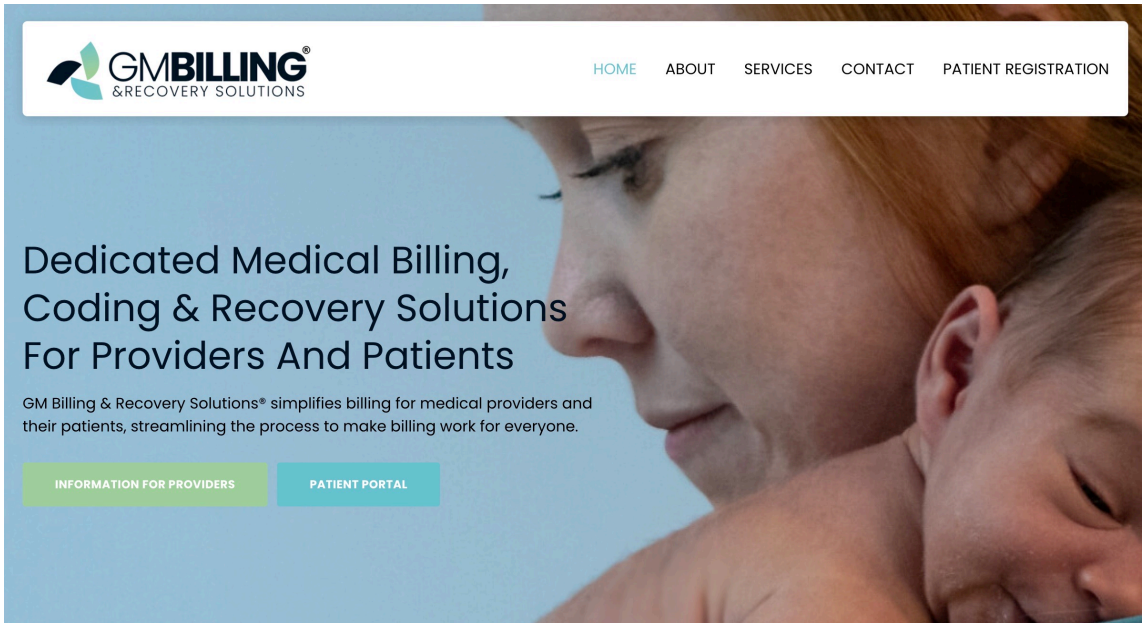
- Julie Moon, MSN, CNM, APRN

- Session 6: Pearls of Billing & Coding in Blended Practices

- Arden Schwenker, CPCO

Registration fees: In-person and Virtual Attendance (CME/CEU provided)*: $200
Student registration: $50
Lunch provided
Dinner Educational Presentation
*Applied for 6 CMEs/6 CEUs

Ahead for 2023...



- ***Growth of GM Billing & Recovery Solutions***
- ***Roll out of NEW service:***

  GM Midwifery Match

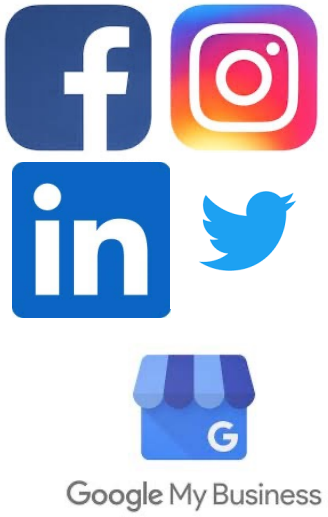
  - Midwife/Employer Services to assist in matching midwife to employment offers
  - Interview midwife and employers to understand want/needs
  - Pre-screen candidates
  - Facilitate fit!

Help Promote #GrowMidwives

Share scope of our work with your friends, colleagues, classmates and inter professional collaborators.

Share your experience and value of work on social media, Google Business reviews, and among peers.

THANK You!



Questions