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Maxine Collins, MBA, CPA, CMC, CMIS, CMOM

On the topic:
Prepare Now for Major Changes to E/M Coding
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PREPARE NOW FOR MAJOR CHANGES TO E/M CODING

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CMS 2019 MEDICARE PHYSICIAN FEE SCHEDULE PROPOSED RULE

• Published in Federal Register on July 27, 2018
• Proposed Rule:

Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program

A Proposed Rule by the Centers for Medicare & Medicaid Services on 07/27/2018

• This document has a comment period that ended September 10, 2018
INTRODUCTION – ITEMS DISCUSSED IN PROPOSED MPFS FOR 2019

• Patients over Paperwork
• Medical Record Documentation Supports Patient Care
• Documenting E/M Requires Choosing Appropriate Code
• Level of E/M visits
• How to Streamline E/M Payment and Reduce Clinician Burden
• Payment for E/M – Established & New Patient
• Additional Payment Codes
• Advancing Virtual Care
• Information

PATIENTS OVER PAPERWORK INITIATIVE

• Focused on reducing administrative burden while improving:
  – Care coordination;
  – Health outcomes; and
  – Patients’ ability to make decisions about their own care.

• CMS states they hear from physicians that “they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.

• “This Administration has listened and is taking action.” How?
  – “Streamlining documentation requirements to focus on patient care; and
  – Modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technology to get the quality care they need.”
MEDICAL RECORD DOCUMENTATION

• “Clear and concise medical record documentation is critical to providing patients with quality care and is required for you to receive accurate and timely payment for furnished services.”
• Supports patient care
• “Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.”

E/M Visits

• Total E/M visits = approximately 40 percent of allowed charges; and Office/outpatient E/M visits = approximately 20 percent of allowed charges.
• Within these percentages, there is significant variation among specialties.
• According to Medicare claims data, E/M visits:
  – Are furnished by nearly all specialties, but represent a greater share of total allowed services for physicians and other practitioners who do not routinely furnish procedural interventions or diagnostic tests.
  – Generally, these practitioners include both primary care practitioners and specialists such as neurologists, endocrinologists and rheumatologists.
  – Certain specialties, such as podiatry, tend to furnish lower level E/M visits more often than higher level E/M visits.
  – Some specialties, such as dermatology and otolaryngology, tend to bill more E/M visits on the same day as they bill minor procedures.
POTENTIAL MISVALUATION OF E/M CODES?

- “Potential misvaluation of E/M codes is an issue that we have been carefully considering for several years.”
- “We have discussed at length in our recent PFS proposed and final rules that the E/M visit code set is outdated and needs to be revised and revalued (for example: 81 FR 46200 and 76 FR 42793).”
- “We have noted that:
  - This code set represents a high proportion of PFS expenditures, but has not been recently revalued to account for significant changes in the disease burden of the Medicare patient population and changes in health care practice that are underway to meet the Medicare population’s health care needs (81 FR 46200)”

Last Year

- CMS sought public comment on potential changes to E/M documentation rules
- Then deferred any decisions to focus on revision of E/M guidelines to reduce administrative burdens
- In CY 2018 Final Rule, CMS summarized public comments received and stated those would be taken into account in any future decision making.

21st CENTURY CURES ACT

- On March 18, 2018, CMS held a listening session seeking input and did so with several other listening sessions hosted by the National Coordinator for Health Information Services (ONC) on the course of implementing section 4001(a) of the 21st Century Cures Act.
  - Provision requires Department of Health and Human Services to establish a goal, develop a strategy, and make recommendations to reduce regulatory or administrative burdens relating to use of EHRs.
  - ONC sessions also sought public input on E/M guidelines as one part of broader, related and unrelated burdens associated with EHRs.
  - Basically, they received different recommendations by specialty.
  - Based on feedback, it was clear that any changes would have substantial specialty-specific impacts, both clinical and financial.
  - Also seemed that history and exam portions of the guidelines were most significantly outdated with respect to current clinical practice.
  - Many stakeholders believed they should be simplified or reduced, but not eliminated.
  - Others felt that guidelines on history and exam could be eliminated altogether, and/or that documentation of these parts could be left to practitioner discretion.


CY 2019 Proposed Policies

- After considering public feedback, CMS proposing several changes to E/M visit documentation and payment.
  - Initially to apply to only office/outpatient visit codes (CPT codes 99201 through 99215), except where otherwise specified.
  - Understand that there are more unique circumstances to consider for E/M code sets used in other settings. May consider doing so in the future.
CURRENT SYSTEM

- 1995 GUIDELINES
- 1997 GUIDELINES
- 3 “KEY” COMPONENTS:
  - 1. History
  - 2. Exam
  - 3. Medical Decision Making

Do you believe that Electronic Health Records have improved medical record documentation?

E/M DOCUMENTATION GUIDELINES

- For coding and billing E/M visits to Medicare, practitioners may use one of two versions of the E/M Documentation Guidelines for a patient encounter, commonly referenced based on the year of their release:
  - The “1995” or “1997” E/M Documentation Guidelines. These guidelines are available on the CMS website.
  - They specify the medical record information within each of the three key components (such as number of body systems reviewed) that serves as support for billing a given level of E/M visit.
  - The 1995 and 1997 guidelines are very similar to the guidelines that reside within the AMA’s CPT codebook for E/M visits.
Table 18—Key Component Documentation
Requirements for Level 2 vs. 3 E/M Visit

<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>History (History of Present Illness or HIP)</td>
<td>Review of systems (ROS)</td>
<td>Focus review of systems related to the problem(s) identified in the HIP</td>
<td>No change from 1995</td>
<td>No change from 1995</td>
</tr>
<tr>
<td>Physical Examination/Assessment</td>
<td>Minimal examination of the affected body area or organ system</td>
<td>A limited examination of the affected body area or organ system and one or more organ system(s) or body area(s)</td>
<td>General multi-system exam. Performance and documentation of at least six elements in one or more organ system(s) or body area(s)</td>
<td>General multi-system exam. Performance and documentation of at least six elements in one or more organ system(s) or body area(s)</td>
</tr>
<tr>
<td>Medical Decision Making (MDM) Reasoned by</td>
<td>**</td>
<td>**</td>
<td>**</td>
<td>**</td>
</tr>
<tr>
<td>1. Problem(s)—number of diagnosis/evaluation options</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Minimal</td>
<td>Minimal</td>
</tr>
<tr>
<td>2. Data/Amount and/or complexity of data to be reviewed</td>
<td>Minimal or No data review</td>
<td>Minimal or No data review</td>
<td>Minimal or No data review</td>
<td>Minimal or No data review</td>
</tr>
<tr>
<td>3. Risk—Risk of complications, major urgency, or mortality</td>
<td>Minimal risk</td>
<td>Minimal risk</td>
<td>Minimal risk</td>
<td>Minimal risk</td>
</tr>
</tbody>
</table>

* For certain settings and patient types, each of these three key components must be met or exceeded (for example, new patient, initial hospital visit). For others, only two of the three key components must be met or exceeded (for example, established patients, subsequent hospital visits).

** Two of three must be met.

**MEDICAL NECESSITY**

- In accordance with section 1862(a)(1)(A) of the Act, which requires services paid under Medicare Part B:
  - To be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member, medical necessity is a prerequisite to Medicare payment for E/M visits.

- The Medicare Claims Processing Manual states:
  - “Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code.”
  - “It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted.”

- The volume of documentation should not be the primary influence upon which a specific level of service is billed.

- Documentation should support the level of service reported

LEVEL OF E/M VISITS

• Code sets were created to bill E/M services as organized into various categories and levels.
  – Generally, the more complex the visit, the higher the level of code a practitioner may bill within the appropriate category.
  – For visits that consists predominately of counseling and/or coordination of care, time can become the “key” or controlling factor to quality for a particular level.
A. LIFTING RESTRICTIONS RELATED TO E/M DOCUMENTATION

• (I). Eliminating extra documentation for Home visits:
  – CPT codes 99341 thru 99350
  – Payment rates slightly higher than office visits (for example, approximately $30 more for a level 5 established patient, non-facility).
  – Beneficiary need not be confined to the home to be eligible for such visit, but there is a Medicare provision requiring that the medical record must document the medical necessity of the home visit made in lieu of an office or outpatient visit (Pub.104-04).
  – Stakeholders suggested that whether visit occurs in home or office is best determined by practitioner without applying additional rules.
  – CMS agrees and proposes to remove requirement for documenting medical necessity of furnishing in the home rather than the office.
  – CMS welcomes public comments on this proposal.

(II). PUBLIC COMMENT COLICITATION ON ELIMINATING PROHIBITION ON BILLING SAME-DAY VISITS BY PRACTITIONERS OF SAME GROUP AND SPECIALTY

• Medicare Claims Processing Manual states:
  – “As for all other E/M services except where specifically noted, the MACs may not pay two E/M office visits billed by a physician (or physician of same specialty from same group) for same beneficiary on same day unless physician documents that visits were for unrelated problems in office, off-campus-outpatient hospital, or on campus-outpatient hospital setting which could not be provided during same encounter. (Pub.100-04).
  – This was intended to reflect idea that multiple visits with same practitioner, or by practitioners in same specialties within a group, on same day as another E/M service could not be medically necessary.
  – Stakeholders provided examples where policy does not make sense as more providers now have multiple specialty affiliations, but only one primary Medicare enrollment specialty.
  – CMS believes that eliminating this policy may better recognize changing practices of medicine while reducing administrative burden.
  – Impact on program expenditures and beneficiary cost sharing is unclear, states CMS and is soliciting public comment.
WHAT ELSE DOES CMS PROPOSE TO DO?

B. Documentation Changes for Office or Other Outpatient E/M Visits and Home Visits

• (I) Providing Choices in Documentation – Medical Decision-Making, Time or Current Framework:
  • Comments received assert that current E/M documentation guidelines are outdated with respect to the current practice of medicine.
    – CMS proposes to allow practitioners to choose, as an alternative to the current framework under 1995 or 1997 guidelines, either MDM or time as a basis to determine appropriate level of E/M visit.
    – Would allow different practitioners in different specialties to choose to document the factor(s) that matter most given nature of clinical practice.
    – Would also reduce impact Medicare may have on standardized recording of history, exam and MDM data in medical records.

(I) Providing Choices in Documentation – Medical Decision-Making, Time or Current Framework:

– Practitioners could use MDM, or time, or they could continue to use current framework to document E/M visits.

– However, payment proposals to be displayed on subsequent slides would apply to all practitioners, regardless of their selected documentation approach.

– All practitioners, even those choosing to retain the current documentation framework, would be paid at proposed new payment rate – that is, one rate for new patients and another rate for established patients. They could also report applicable “G” codes created in new system by CMS which will be shown later.
STREAMLINE E/M PAYMENT AND REDUCE CLINICIAN BURDEN

• To Streamline E/M Payment and Reduce Clinician Burden?
  – By providing practitioners choice in documentation of office/outpatient based E/M visits for Medicare PFS Payment:
    1. 1995 or 1997 Guidelines;
    2. Medical decision-making; or
    3. Time
  – By expanding current policy regarding history and exam, to allow practitioners to focus documentation on:
    • What has changed since the last visit; or
    • Pertinent items that have not changed, rather than re-documenting information;
    • Provided they review and update the previous information.
  – By allowing practitioners to review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.
  – By soliciting comment on how documentation guidelines for medical decision making might be changed in subsequent years.

PROPOSED PAYMENT FOR OFFICE/OUTPATIENT BASED E/M VISITS

<table>
<thead>
<tr>
<th>LEVEL</th>
<th>CURRENT PMT* (ESTABLISHED PATIENTS)</th>
<th>PROPOSED PAYMENT**</th>
<th>LEVEL</th>
<th>CURRENT PMT* (NEW PATIENT)</th>
<th>PROPOSED PAYMENT**</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>$ 22</td>
<td>$ 24</td>
<td>1</td>
<td>$ 45</td>
<td>$ 44</td>
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<td>5</td>
<td>$148</td>
<td></td>
<td>5</td>
<td>$ 211</td>
<td></td>
</tr>
</tbody>
</table>

*Current Payment for CY 2018
**Proposed Payment based on CY 2019 proposed relative value units and the CY 2018 payment rate.
PROPOSED PAYMENT FOR OFFICE/OUTPATIENT BASED E/M VISITS

- A single payment rate for E/M visit levels 2-5 (physician and non-physician) for new and established patients.

- A minimum documentation standard where, for Medicare PFS payment purposes, practitioners would only need to document the information to support a level 2 E/M visit.

- Wonder if they are going to return all that money the RACs recovered for not following the “outdated” E/M guidelines (their own term for the Guidelines they used in auditing prior paid E/M visits)?

EXAMPLE FOR DR. CHOOSING TO DOCUMENT UNDER CURRENT GUIDELINES - 95 OR 97

- Proposed minimum documentation for any billed level of E/M from levels 2 through 5 could include:
  - Problem-focused history that does not include a Review of Systems or a Past, Family, or Social History;
  - Limited Examination of the affected area or organ system; and
  - Straightforward Medical Decision-Making measured by minimal problems, data review and risk (two of these three).

- If practitioner was choosing to document based on MDM alone, Medicare would only require documentation supporting Straightforward Medical Decision-Making measured by minimal problems, data review, and risk (two of these three).
BASING E/M LEVEL ON TIME

• Proposal:
  – To allow practitioners the choice of using time to document office/outpatient E/M visits:
    • Time-based standard would not be limited to E/M visits in which counseling and/or care coordination accounts for more than 50% of face-to-face practitioner/patient encounter.
    • Rather, the amount of time personally spent by the billing practitioner face-to-face with the patient could be used to document E/M visit regardless of amount of counseling and/or care coordination was furnished as part of face-to-face encounter.
  – Some that commented were concerned about this reliance on time because of abuse, inequities among more-or-less efficient practitioners, and specialties for which time is less of a factor in determining visit complexity.

BASING E/M LEVEL ON TIME - CONTINUED

  – Relying on time also raises issue of required supporting documentation – what amount of time should be documented, and whether specific activities comprising time need to be documented and, if so, to what degree?
  – CMS agrees that for some specialties, time may be a good indicator of complexity of visit and is proposing to allow providers the option to use time as a single factor in selecting visit level and documenting E/M visit. If finalized, CMS states they will monitor results of policy for program integrity issues, administrative burdens or other issues.
  – CMS proposes that for practitioners choosing to support coding and payment by documenting amount of time, to require practitioner to document the medical necessity of the visit and show total amount of time spent face-to-face with patient.
  – CMS is soliciting comments on this proposal
CMS SOLICITING COMMENTS ON WHAT TOTAL TIME SHOULD BE FOR NEW RATED E/M LEVELS 2 THROUGH 5

- Proposal:
  - Typical time for proposed is 31 minutes for an established patient; and
  - 38 minutes for a new patient.
  - These times are a weighted average of intra-service time for a level 2, 3 or 4 visit, but lower than current time for level 5 visit.
  - One alternative is to apply AMA’s CPT codebook provision, that for timed services, a unit of time is attained when the mid-point is passed. Therefore, documentation would be required for at least 16 minutes for an established patient and 20 minutes for a new patient.
    - So if provider chose to document based on time, the above could be used to support the level.

CMS SOLICITING COMMENTS ON WHAT TOTAL TIME SHOULD BE FOR NEW RATED E/M LEVELS 2 THROUGH 5

- Another alternative is to require documentation that the typical time for the CPT code that is reported (which is also the typical time listed in the AMA’s CPT codebook for that code) was spent face-to-face by billing provider with patient.
  - Example: A Practitioner reporting CPT code 99212 would be required to document having spent a minimum of 10 minutes; and
  - A practitioner that reporting CPT code 99214 would be required to document a minimum of 25 minutes.
  - CMS realizes that this approach of requiring documentation of typical time associated with CPT visit code reported on claim would introduce unique payment implications for reporting that code, especially when the time associated with the billed E/M code is the basis for reporting prolonged E/M services.
  - CMS seeking public comments on these alternatives.
Prolonged E/M Services

• Currently when reporting prolonged E/M services:
  – Expect practitioner to exceed typical time assigned for base E/M visit code.
  – In proposed rule, giving practitioner option to base level on time and also reports prolonged E/M services, CMS would require provider to document that the typical time required for the base visit is exceeded by the amount required to report prolonged services.
  – Primary goal is to reduce administrative burden so practitioner can focus on patient. CMS interested in commenter’s opinions as to whether their E/M visit proposals would, in fact, support and further this goal.
  – CMS would expect practitioners to continue to perform and document E/M visits as medically necessary for the patient to ensure quality and continuity of care.

(II) REMOVING REDUNDANCY IN E/M VISIT DOCUMENTATION

• Stakeholders have requested in previous comments that:
  – CMS should not require documentation of information in billing notes that is already present, particularly in regard to history for established patients (eg. ROS/PFSH).
  – CMS proposes that for history and exam for established patients, practitioners would only be required to focus documentation on what has changed since the last visit or on pertinent items that have not changed.
  – CMS would expect that practitioners to still conduct relevant and medically necessary elements of history and physical exam, and conform to general principles of medical record documentation in the 1995 and 1997 guidelines.
  – However, they would not need to re-record these elements (or parts thereof) if there is evidence that the practitioner reviewed and updated the previous information.
  – CMS is seeking public comment on whether there may be ways to implement a similar provisions for any aspects of medical decision-making or for new patients, such as when prior data is available to billing provider through an interoperable EHR or other data exchange.
(III) PODIATARY VISITS

- Proposal:
  - To create separate coding for podiatry visits currently reported as E/M office/outpatient visits.
    - Rather than reporting visits general E/M office/outpatient visit code set, podiatrist would report visits under new “G” codes that more specifically identify and value their services.
    - Propose to apply substantially same documentation standards for new proposed podiatry-specific codes as proposed for other office/outpatient E/M visits.
      - Could choose to use time.
      - Typical times would be 22 minutes for an established patient and 28 minutes for a new patient.
      - Alternatively, could apply AMA’s CPT codebook provision of the mid-point – at least 12 minutes for an established patient and at least 15 minutes for new patient face-to-face to support making payment for these codes when physician chooses to document the visit using time.
  - CMS soliciting comments.

C. MINIMIZING DOCUMENTATION REQUIREMENTS BY SIMPLIFYING PAYMENT AMOUNTS

- CMS believes current set of 10 CPT codes for E/M visit no longer reflect complete services and resource costs associated with furnishing E/M services to all patients across different physician specialties.
- Proposing to develop a single set of RVUs under the PFS for E/M office-based and outpatient visit levels 2 through 5.
- Considered creating new “G” codes but abandoned idea.
- A single payment rate will eliminate increasingly outdated distinction between kinds of visits currently reflected in levels.
- Proposing work RVU of 1.90 for CPT codes 99202-99205, physician time of 37.79 minutes, and direct PE inputs of $24.98, each based on an average of current inputs for individual codes weighted by 5 years of accumulated utilization data.
- Proposing work RVU of 1.22 for CPT codes 99212-99215, with physician time of 31.31 minutes and direct PE inputs equal to $20.70, also based on weighted average of 5 years data.
TABLE SHOWING PAYMENT RATES – NEW PATIENT

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>CY 2018 NON-FACILITY PAYMENT RATE</th>
<th>CY 2018 NON-FACILITY RATE UNDER PROPOSED METHODOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>$45</td>
<td>$44</td>
</tr>
<tr>
<td>99202</td>
<td>$76</td>
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<td>99204</td>
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<tr>
<td>99205</td>
<td>$211</td>
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</tr>
</tbody>
</table>

Under proposal, now who has control of our “bundled” payment rates?

TABLE SHOWING RATES – ESTABLISHED PATIENT

<table>
<thead>
<tr>
<th>HCPCS CODE</th>
<th>CURRENT NON-FACILITY PAYMENT RATE</th>
<th>PROPOSED NON-FACILITY PAYMENT RATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>99211</td>
<td>$22</td>
<td>$24</td>
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<td>99215</td>
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</table>
D. RECOGNIZING RESOURCE COSTS FOR DIFFERENT TYPES OF E/M VISITS

• CMS believes that rather than maintain distinctions in services and payments based on current E/M visit codes, they can better capture differential resources costs and minimize reporting and documentation burdens by proposing several corollary payment policies and rate setting adjustments.

– Primary care visits – respondents stated that the current system does not appropriately reimburse for primary care and visits associated with patients that do not involve additional procedural coding.

RECOGNIZING RESOURCE COSTS FOR DIFFERENT TYPES OF E/M VISITS

– Therefore, proposing following adjustments to better capture variety of resources associated with different types of care:

1. An E/M multiple procedure payment adjustment to account for duplicative resource cost when E/M visit and procedures with global periods are furnished together;

2. HCPCS G-code add-ons to recognize additional relative resources for primary care visits and inherent visit complexity that require additional work beyond that which is accounted for in the single payment rates for new and established patient levels 2 through 5;

3. HCPCS G-codes to describe Pediatric E/M visits;

4. An additional Prolonged face-to-face services add-on G code; and

5. A technical modification to the PE Methodology to stabilize the allocation of indirect PE for visit services (ii) Accounting for E/M Resource Overlap between Stand-Alone Visits and Global Periods.
MULTIPLE PROCEDURE ADJUSTMENT – GOOD BYE 25 MODIFIER!

- Using MPPR as a template, CMS is proposing that, as part of proposal for payment of E/M levels 2-5 at single rate:
  - They propose to reduce payment by 50% for the least expensive procedure or visit by same physician (or physician in same group) furnished on same day as separately identifiable E/M visit, currently identified on claim by appending modifier “25”.
  - This would reduce expenditures under PFS by approximately 6.7 million RVUs which will be allocated toward the values of the add-on codes that reflect additional resource costs of different types of E/M visits for primary care and inherent visit complexity, similar to existing policies.

(II) PROPOSED HCPCS G-CODE ADD-ONS

- CMS has found distribution of E/M visits is not uniform across medical specialties.
- Certain specialties bill higher level E/M codes more frequently than procedural specialists(or testing services), such a Dermatology. Examples are:
  - Neurologists
  - Endocrinologists
- Primary care, however, they state requires additional time to communicate with patient, patient education, and review of medical records.
- GPC1X – Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an established patient evaluation and management visit.)
GPC1X

- Can also be used for other forms of face-to-face care management, counseling, or treatment of acute or chronic conditions not accounted for by other coding.

- Only associated with stand-alone E/M visits as opposed to separately identifiable visits furnished within the global period of a procedure. These would be identified on the claim by using modifier 25 and would be subject to MPPR.

- CMS notes that there is already separate coding that describe non-face-to-face care management and coordination, such as CCM and BHI; however, these services can be provided by any specialty so long as they meet requirements of the code.

- GPC1X would be billed in addition to the E/M visit for an established patient when the visit includes Primary Care Services with a proposed RVU of 0.7, physician time of 1.75 minutes, PE RVU of 0.07, and MP RVU of 0.01.

GPC1X - CONTINUED

- Distinguishes Primary Care Services and CMS expects this code would be billed with every primary-care focused E/M visit for established patients.

- While CMS expects this code to be used mostly by primary care specialties, such as Family Practice and Pediatrics, they are aware that, in some instances, certain specialists function as primary care practitioners- for example, an OB/GYN or a Cardiologist. Although the definition of primary care is widely agreed upon by the medical community and we intend this G-code to account for resource costs of performing those types of visits, regardless of Medicare enrollment specialty, we are also seeking comment on how best to identify whether or not a primary care visit was furnished particularly in cases where a specialist is providing those services.

- For especially complex patients, CMS also expects that the G code may be billed along side the proposed new code for prolonged E/M Services described later in this section.
NEW “G” CODE TO REPORT ADDITIONAL RESOURCES FOR SPECIALTY PROFESSIONALS

To be reported with an E/M service to describe:

– Additional resource costs for specialty professionals for whom E/M visit codes make up large % of overall allowed charges; and
– Whose treatment approaches are generally reported using level 4 and level 5 visit codes rather than procedural coding.
– Due to these facts, the proposed single level rate for levels 2-5 would not necessarily reflect resource costs of those types of visits.
– Therefore, propose to create new HCPCS code GCG0X – Visit inherent to E/M associated with:
  • Endocrinology, Rheumatology, Hematology/Oncology, Urology, Neurology, OB/GYN, Allergy/Immunology, Otolaryngology, Cardiology, or Interventional Pain management-centered care
  • Given these specialties billing patterns, CMS believes these apply predominately to non-procedural approaches to complex conditions that are intrinsically diffuse to multi-organ or neurologic diseases.
  • While some are surgical in nature, CMS believes these are providing increased non-procedural care of high complexity in the Medicare population.
  • When billing the new G code in conjunction with stand alone office/outpatient E/M visit for new and established patients, the combined valuation will more accurately account for the intensity associated with higher level E/M visits.

NEW HCPCS CODE GCG0X

• Proposing a crosswalk to 75% of the work and time of CPT code 90785 (Interactive complexity) which results in a work RVU of 0.25, a PE RVU of 0.07, and an MP RVU of 0.01, with 8.25 minutes of physician time (based on CY 2018 valuation for 90785).
• CMS proposing that the specialty of psychiatry would not use either of the new add-on codes because psychiatrists may utilize CPT code 90785 to describe work that might otherwise be reported with a level 4 or 5 E/M visit.
(III) PROPOSED NEW HCPCS G CODES FOR PODIATRIC E/M VISITS

- Proposing two new G codes:
  - **GPD0X** – Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, new patient; (work RVU of 1.35, physician time of 28.11 minutes, direct PE inputs totaling $22.53)
  - **GPD1X** – Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, established patient; (work RVU 0.85, physician time of 21.60 minutes, and direct PE inputs totaling $17.07).
- These would be used for Podiatric E/M services instead of the generic CPT codes 99201-99205 and 99211 through 99215.
- Taking into account that most Podiatric visits are billed with current level 2 or 3 E/M codes.
- New codes are being based on CPT codes 99204 (Ophthalmological services: Medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient (1 or more visits) and 92012 (Ophthalmological services: medical examination and evaluation, with initiation or continuation of diagnostic and treatment program; intermediate, established patient).

SUMMARY PROPOSED ADDITIONAL PAYMENT CODES FOR 2019

- **$ 5 Add-on payment** to recognize additional resources to address inherent complexity in E/M visits associated with Primary Care services.
- **$ 14 Add-on payment** to recognize additional resources to address inherent visit complexity in E/M visits associated with certain non-procedural based care.
- A multiple procedure payment adjustment that would reduce the payment when an E/M service is furnished in combination with a procedure on the same day, same patient. (“Bye, Bye 25 Modifier” and “Hello 50% reduction on lower paying additional service”?)
- **$ 67 Add-on payment for a 30 minute prolonged E/M visit.**
- **Now who will have control over reimbursement for our “packaged E/M codes and bundled services”?**
(IV) PROPOSED ADJUSTMENT TO PE/HR CALCULATION

• CMS generally allocates indirect costs for each code on basis of direct costs specifically associated with a code and:
  – The greater of either the clinical labor cost; or
  – The work RVUs.

• Indirect expenses include:
  – Administrative labor, office expense and all other PEs that are not directly attributable to a particular service for a particular patient.
  – Generally, the proportion of indirect PE allocated to a service is determined by calculating a PE/HR based upon the mix of specialties that bill for a service.
  – As already established, E/M visits comprise a large portion of allowable charges and are used broadly across specialties such that new proposed payment system rates could have a significant effect on many specialties - due to the way that indirect PE is allocated based on the mixture of specialties that furnish a services. They do not know the resulting impact of these changes and are therefore:
    • Proposing to create a single PE/HR value for E/M visits (including all of the proposed HCPCS G codes)
      of approximately $136, based on an average of the PE/HR across all specialties that bill these codes,
      weighted by the volume of those specialties’ allowed E/M services.
    • CMS believes this new PE/HR value will more accurately reflect the mix of specialty billing both the generic E/M code set and the add-on codes.
    • If this is finalized, CMS will consider revisiting the PE/HR after several years of claims data becomes available.

(V) PROPOSED HCPCS G-CODE FOR PROLONGED SERVICES

• CPT codes 99354 (Prolonged E/M or psychotherapy service(s) beyond the typical service time of the primary procedure(s) in office or other outpatient setting requiring direct patient contact beyond the usual service, first hour (List separately in addition to code for E/M or psychotherapy service) and 99354, each additional 30 minutes.

• Comments have indicated that the “first hour” threshold in the descriptor for 99354 is difficult to meet and is an impediment to billing these codes.

• CMS proposes to create a new HCPCS code GPRO1 – Prolonged E/M or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service: 30 minutes (List separately in addition to code for office or other outpatient E/M or psychotherapy service)).
  – Given that time is half of what is listed in 99354, CMS proposes an RVU of 1.17 (half of current code).
## TABLE SHOWING ESTIMATED CHANGES FOR CERTAIN SPECIALTIES

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Podiatry</td>
<td>$2,022</td>
<td>12%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>3,535</td>
<td>7%</td>
</tr>
<tr>
<td>Hand Surgery</td>
<td>202</td>
<td>8%</td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>1,220</td>
<td>3%</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>3,815</td>
<td>4%</td>
</tr>
<tr>
<td>Oral/Maxillofacial Surg.</td>
<td>57</td>
<td>4%</td>
</tr>
<tr>
<td>Colon/Rectal Surgery</td>
<td>368</td>
<td>LESS THAN 3% INCREASE IN OVERALL PAYMENT</td>
</tr>
<tr>
<td>OR/GYN</td>
<td>664</td>
<td>”</td>
</tr>
<tr>
<td>Optometry</td>
<td>1,276</td>
<td>”</td>
</tr>
<tr>
<td>Physician Assistant</td>
<td>2,213</td>
<td>”</td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>387</td>
<td>”</td>
</tr>
<tr>
<td>Allergy/Immunology</td>
<td>340</td>
<td>MINIMAL CHANGE TO OVERALL PAYMENTS</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>1,995</td>
<td>”</td>
</tr>
<tr>
<td>Audiologist</td>
<td>67</td>
<td>”</td>
</tr>
<tr>
<td>Cardiac Surgery</td>
<td>313</td>
<td>”</td>
</tr>
<tr>
<td>Chiropractor</td>
<td>709</td>
<td>”</td>
</tr>
<tr>
<td>Critical Care</td>
<td>524</td>
<td>”</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1,196</td>
<td>”</td>
</tr>
<tr>
<td>Family Practice</td>
<td>6,382</td>
<td>”</td>
</tr>
<tr>
<td>Gastroenterology</td>
<td>1,807</td>
<td>”</td>
</tr>
</tbody>
</table>

### OTHER SPECIALTIES ESTIMATED WITH MINIMAL CHANGE TO OVERALL PAYMENT

- General Practice
- General Surgery
- Infectious Disease
- Interventional Pain Mgt
- Interventional Radiology
- Multispecialty Clinic
- Neurosurgery
- Nuclear Medicine
- Nurse Practitioner
- Ophthalmology
- Other
- Pathology
- Physical Medicine
- Psychiatry
- Rad.Onc/Rad.Therap
- Radiology
- Thoracic Surgery
- Urology
- Vascular Surgery
### THOSE SPECIALTIES WITH ESTIMATED LESS THAN 3% DECREASE IN OVERALL PAYMENTS

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>ALLOWED CHARGES (IN MILLIONS)</th>
<th>EST. DECREASE IN OVERALL PAYMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>CARDIOLOGY</td>
<td>6,723</td>
<td>LESS THAN 3% EST. DECREASE</td>
</tr>
<tr>
<td>INTERNAL MEDICINE</td>
<td>11,173</td>
<td>&quot;</td>
</tr>
<tr>
<td>NEPHROLOGY</td>
<td>2,285</td>
<td>&quot;</td>
</tr>
<tr>
<td>PEDIATRICS</td>
<td>64</td>
<td>&quot;</td>
</tr>
<tr>
<td>PULMONARY DISEASE</td>
<td>1,767</td>
<td>&quot;</td>
</tr>
<tr>
<td>GERIATRICS</td>
<td>214</td>
<td>- 4%</td>
</tr>
<tr>
<td>RHEUMATOLOGY</td>
<td>559</td>
<td>- 7%</td>
</tr>
<tr>
<td>NEUROLOGY</td>
<td>1,565</td>
<td>- 7%</td>
</tr>
<tr>
<td>HEMATOLOGY/ONCOLOGY</td>
<td>1,813</td>
<td>- 7%</td>
</tr>
<tr>
<td>ENDOCRINOLOGY</td>
<td>482</td>
<td>- 10%</td>
</tr>
</tbody>
</table>

### TABLE SHOWING POTENTIAL IMPACT OF VALUING LEVELS 2-5 TOGETHER, WITH ADDITIONAL ADJUSTMENTS

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>ALLOWED CHARGES (IN MILLIONS)</th>
<th>EST. IMPACT OF VALUING LEVELS 2-5 WITH ADDTL ADJS</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB/GYN</td>
<td>$ 664</td>
<td>4%</td>
</tr>
<tr>
<td>NURSE PRACTITIONER</td>
<td>3,586</td>
<td>3%</td>
</tr>
<tr>
<td>HAND SURGERY</td>
<td>202</td>
<td>LESS THAN 3% EST. INCREASE IN OVERALL PAYMENT</td>
</tr>
<tr>
<td>INTERVENTIONAL PAIN MGMT</td>
<td>839</td>
<td>*</td>
</tr>
<tr>
<td>OPTOMETRY</td>
<td>1,276</td>
<td>*</td>
</tr>
<tr>
<td>PHYSICIAN ASSISTANT</td>
<td>2,253</td>
<td>*</td>
</tr>
<tr>
<td>PSYCHIATRY</td>
<td>1,260</td>
<td>*</td>
</tr>
<tr>
<td>UROLOGY</td>
<td>1,772</td>
<td>*</td>
</tr>
<tr>
<td>ANESTHESIOLOGY</td>
<td>1,995</td>
<td>MINIMAL CHANGE</td>
</tr>
<tr>
<td>CARDIAC SURGERY</td>
<td>313</td>
<td>*</td>
</tr>
<tr>
<td>CARDIOLOGY</td>
<td>6,723</td>
<td>*</td>
</tr>
<tr>
<td>CHIROPRACTOR</td>
<td>789</td>
<td>*</td>
</tr>
<tr>
<td>COLON AND RECTAL SURGERY</td>
<td>168</td>
<td>*</td>
</tr>
<tr>
<td>CRITICAL CARE</td>
<td>334</td>
<td>*</td>
</tr>
<tr>
<td>EMERGENCY MEDICINE</td>
<td>3,196</td>
<td>*</td>
</tr>
</tbody>
</table>
OTHER SPECIALTIES WITH ESTIMATED MINIMAL CHANGE IN OVERALL PAYMENT

- Endocrinology
- Family practice
- Gastroenterology
- General practice
- General surgery
- Geriatrics
- Infectious disease
- Internal medicine
- Interventional radiology
- Multispecialty clinic
- Nephrology
- Nuclear medicine
- Ophthalmology
- Otol/maxillofacial surg.
- Orthopedic surgery
- Other
- Pathology
- Pediatrics
- Physical medicine
- Plastic surgery
- Radiology
- Thoracic surgery
- Vascular surgery

TABLE SHOWING IMPACT OF VALUING LEVELS 2-5 TOGETHER, WITH ADDITIONAL ADJUSTMENTS

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>ALLOWED CHARGES (IN MILLIONS)</th>
<th>EST. POTENTIAL IMPACT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ALLERGY/IMMUNOLOGY</td>
<td>$240</td>
<td>LESS THAN 3% EST. DECREASE IN OVERALL PAYMENT</td>
</tr>
<tr>
<td>AUDIOLOGIST</td>
<td>67</td>
<td>“</td>
</tr>
<tr>
<td>HEMATOLOGY/ONCOLOGY</td>
<td>1,813</td>
<td>“</td>
</tr>
<tr>
<td>NEUROLOGY</td>
<td>1,565</td>
<td>“</td>
</tr>
<tr>
<td>OTOLARYNGOLOGY</td>
<td>1,220</td>
<td>“</td>
</tr>
<tr>
<td>PULMONARY DISEASE</td>
<td>1,767</td>
<td>“</td>
</tr>
<tr>
<td>RADIATION ONCOLOGY AND RAD. THERAPY CENTERS</td>
<td>1,776</td>
<td>“</td>
</tr>
</tbody>
</table>
TABLE SHOWING SPECIALTIES WITH ESTIMATED POTENTIAL DECREASES IN OVERALL PAYMENT

<table>
<thead>
<tr>
<th>SPECIALTY</th>
<th>ALLOWED CHARGES (IN MILLIONS)</th>
<th>EST. POTENTIAL DECREASE BY VALUING LEVELS 2-5 TOGETHER, WITH ADDTL ADJS.</th>
</tr>
</thead>
<tbody>
<tr>
<td>RHEUMATOLOGY</td>
<td>$559</td>
<td>-3%</td>
</tr>
<tr>
<td>DERMATOLOGY</td>
<td>3,525</td>
<td>-4%</td>
</tr>
<tr>
<td>PODIATRY</td>
<td>2,022</td>
<td>-4%</td>
</tr>
</tbody>
</table>

CMS NOTES:

- “The Specialties that we estimate would experience a decrease in payments are those that bill a large portion of E/M visit on same day as procedures, and would see a reduction based on application of the MPPR adjustments.”
- “Also for the purposes of our modeling, we assumed that specialties including endocrinology, rheumatology, hematology/oncology, urology, neurology, Ob/Gyn, allergy/immunology, otolaryngology, or interventional pain management-centered care utilized the G-code for visit complexity inherent to E/M with every office/outpatient E/M visit.”
- “The Table does not include the impact of the use of additional prolonged services code.”

Advancing “Virtual Care”

- CMS received feedback from stakeholders that support the “expansion of access to services that support technological developments in healthcare.”
- CMS is interested in “recognizing changes in healthcare practices that incorporate innovation and technology in managing patient care.”
- Aiming to “increase access for Medicare beneficiaries for physician services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology.”
Advancing “Virtual Care” CONTINUED

- CMS is proposing to:
  - Pay clinicians for virtual check-ins – brief, non-face-to-face assessments via communication technology;
  - Pay for Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit;
  - Pay clinicians for evaluation of patient-submitted photos or recorded video; and
  - Expand Medicare-covered telehealth services to include prolonged preventive services

For Further Information, see the Physician Fee Schedule website at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html.

COMMENTS WERE ACCEPTED BY CMS UNTIL SEPTEMBER 11, 2018

A FEW EXAMPLES OF COMMENTS RECEIVED
Comment - OREGON

- 1) “Reducing payment for higher level E/M services creates a disincentive to performing in-depth evaluation and management. That is THE LAST thing our patients need, is to have their complaints and problems be treated “shallowly” by their government, or their physicians. I STRONGLY PROTEST the proposal to remove reimbursement for more complete patient management services.

- 2) “Cutting the reimbursement rate of the lower-cost of E/M services, and procedures (specifically Osteopathic Manipulative Medicine) services provided in the same visit, likewise removes incentive for physicians to serve all the needs of their patient in every visit. As an Osteopathic Manipulative Medicine specialist, I DO NOT TREAT MY PATIENTS WITHOUT EXAMINING THEM!!!! To suggest otherwise, or to demand otherwise, is akin to the California debacle of the 1960s, declaring that Doctors of Osteopathy were unfit to practice medicine in the state, but if they would buy a $50.00 M.D. license, suddenly they were capable of medical practice.”

- “I am AGHAST that CMS is considering such a slight to the profession I have served with all my heart for 3 decades.”

“Do NOT make these changes to a system which (mostly) works. Try putting your efforts into the unconscionable raising of medication prices, instead.”

COMMENT - ALABAMA

- “Dear Administrator Verma:

I am writing to urge the Centers for Medicare and Medicaid Services (CMS) to abandon its proposal to reduce reimbursement by 50% for the least expensive component of an encounter when modifier 25 is appropriately used. I am concerned that this policy proposal is based on flawed assumptions and would lead to significant reductions in reimbursement that could negatively impact my ability to serve my patients. In addition, CMS has ignored both the RUC’s and CMS’s history of making reductions to the values of procedures typically performed on the same day as an evaluation and management (E/M) service to remove redundancies in work and practice expense.

As a practicing ophthalmologist who treats Medicare beneficiaries, I often append modifier 25 to my claims to indicate that a separate and identifiable E/M service has been performed at the same time as a minor procedure. Physicians often identify problems which may not be the chief complaint of the patient, once detected my patients frequently ask me to address these multiple unrelated concerns, and I can provide the best care by addressing those concerns on the same visit.

It is not good policy to arbitrarily penalize physicians for meeting the needs of their patients with a significant payment cut that fails to take into account that the areas of overlap and “efficiencies gained” have already been reduced – even when the procedure code is billed independently of a concurrent E/M service. Furthermore, it can affect patients’ access to care in a timely manner.”
COMMENTS FROM ALABAMA – CONTINUED

- I agree with CMS that the existing E/M codes are complicated and cumbersome. This is a system that is long overdue for an overhaul. However, CMS should not unilaterally collapse the E/M codes and create G-codes to “fix” payment anomalies that this collapse would create. Rather, I strongly urge CMS to work with the CPT/RUC E/M workgroup, which includes ophthalmology to develop an alternative E/M coding structure that is grounded in the concept of relativity and that is resource based. While I appreciate that CMS is trying to simplify its documentation requirements, I do not believe this proposal will reduce my burdens.

I also am concerned that CMS unilaterally developed a separate and unique set of E/M codes for podiatrists that are different from what other Medicare providers use for E/M services, at a significantly lower rate of reimbursement. Instead of making unilateral decisions about code sets and values, I would respectfully urge CMS to work with physicians through the specialty societies and the AMA RUC and CPT in making such policy and reimbursement changes.

For all of these reasons, I respectfully urge CMS to withdraw the proposed modifier 25 reimbursement reduction policy and to delay a modified structure for E/M until a consensus between physicians and CMS on an equitable new coding structure is achieved.”

COMMENT – OHIO

- As an osteopathic physician, I would like to thank the Centers for Medicare & Medicaid Services (CMS) for its efforts to reduce administrative regulatory burdens for physicians by proposing to simplify documentation requirements for office and other outpatient Evaluation and Management (E/M) visits for new patients (CPT codes 99202-99205) and established patients (99212-99215).

However, I am concerned that collapsing payment rates for eight E/M visits down to two rates will not achieve its goal of reducing regulatory burden. I also disagree with the proposal to implement a multiple procedure payment reduction policy that would cut procedures by 50 percent when billed with an E/M visit appended with Modifier 25. Both of these proposals run counter to the Patients Over Paperwork Initiative, which aims to streamline regulations and reduce unnecessary burden. If CMS top priority is to put patients first, these policies, if finalized, may have unintended consequences that threaten Medicare beneficiaries’ ability to access care. Frail and elderly beneficiaries with complex medical conditions stand to suffer the most, as they may have to seek care through multiple office visits. Ultimately, I believe these changes would decrease patient satisfaction and quality of care.

While the effort to reduce documentation and administrative burden is appreciated, I urge CMS to immediately abandon the proposed Modifier 25 reimbursement reduction policy, and delay finalizing payment rates for office and other outpatient E/M visits to allow time to work with the American Medical Association/Specialty Society RVS Update Committee (RUC) to develop appropriate rates for different level visits.
**COMMENT - MN**

- Dear Administrator Verma:

As a practicing gastroenterologist increasingly overwhelmed by the administrative requirements imposed by payers, including Medicare, I applaud the agencies recent efforts to put Patients over Paperwork, and I sincerely appreciate CMS desire to provide administrative relief to physicians caring for Medicare beneficiaries.

It is unclear whether proposed E/M documentation changes will meaningfully reduce burden for my practice. Moreover, CMS position that improvements in E/M documentation may only occur if payments for new and established level 2-5 outpatient visits are blended into a single payment rate is alarming, as is the proposed payment reduction for visits or procedures performed on the same day as an E/M service. I object to the proposed changes impacting E/M services and ask that they not be finalized.

My practice faces numerous administrative and regulatory burdens, from payer utilization management strategies, such as prior authorization and step therapy appeals, as well as added time and cost to participate in CMS quality reporting programs. I do not get reimbursed for these services, yet they put a significant strain on my practice. CMS E/M proposal should be withdrawn at this time.

Sincerely,

Sundeep Arora

---

**COMMENT - PA**

Dear CMS,

I am a Family Physician that has been teaching coding and documentation for Altru Health System for the past 16 years. I feel that that dropping the History and Exam criteria for coding and focusing just on Medical Decision Making is a wonderful idea and would simplify coding and documentation.

I strongly feel that dropping level 2 through 5 office visits for one level/payment is a very bad idea and will lead to poor patient care, a marked increase in patient visits and lead to much higher costs.

This proposal rewards high volume physicians who see a large number of patients a day for quick visits and address only 1 or 2 problems per visit. This proposal punishes good physicians that spend the time needed to care for patients that present with multiple complex problems (which is the major of our Medicare patient visits).

Paying the same for seeing someone for 5-10 minutes for a sore throat versus seeing a patient for 25 to 45 minutes who presents with weight loss, memory problems, or coexisting heart, lung and kidney problems etc makes no sense what so ever. You will force good physicians to spend less time with their patients, leading them to schedule extra recheck visits to address all their medical problems and lead them to make more referrals to expensive specialists because the patients family physician or internist is no longer compensated to do a good thorough job and address all their current problems.

This proposal will result in frustrated patients, angry doctors, greatly increase medical costs and will reward poor care. Focus on Medical Decision Making, leave levels 99212-99215 visits alone.
COMMENT - NY

- As a psychologist who provides neuropsychological testing services to Medicare patients, I am writing to comment on your agency’s proposed Medicare Physician Fee Schedule for 2019, and its effect on both psychologists like me and on my patients.
- I practice in an urban medical center and the majority of my patients are elderly or low-income patients insured with Medicare and Medicaid. I was unable to cover my fees with the prior reimbursement rates—any substantial cut to reimbursement would require me to discontinue seeing these patients, many of whom would be unable to be evaluated elsewhere.
- In the future, I urge you to work toward higher reimbursement rates for these services.

The risk of cognitive decline increases with age. It is likely that you, and your loved ones, will have a need for our services at some point in the future.

Thank you for considering my views on this issue.

CMS Considered Other Alternatives

- Establishing single payment rates for new and established patients for combined E/M visit levels 2-4. This would have retained a separately valued payment rate for the higher level 5.
- Regarding emergency department visits (CPT codes 99281-85), CMS received comments that these codes may benefit from a coding or payment compression into fewer levels, or that documentation rules may need to be reduced or altered.
- CMS proposes that E/M visit policies take effect January 1, 2019. However, they are sensitive to commenters’ suggestions to consider a multi-year process and proceed continuously, allowing adequate time to educate practitioners and their staff, and to transition clinical workflows, EHR templates, institutional processes and policies, etc.
- A Final Proposed Rule will be issued in November, 2018 and it will also have a comment period prior to the publication of the Final Rule for the 2019 Medicare Physician Fee Schedule.
Resource

• The source for all information in this presentation:
  – Calendar Year (CY) 2019 Medicare Physician Fee Schedule (PFS) Proposed Rule. Documentation Requirements and Payment for Evaluation and Management (E/M) Visits and Advancing Virtual Care”
  – www.cms.gov

QUESTIONS

• Comments?
• Thank you!!!
• Contact information:
  Maxine Collins, MBA, CPA, CMC, CMIS, CMOM
  Email mcollins@pmimd.com
  Phone: 940-631-4279
Evaluation and Management (E/M) Update 2019

Summary of Final Rule

The massive changes to Evaluation and Management (E/M) that the Centers for Medicare & Medicaid Services (CMS) originally proposed do not appear in the final 2019 physician fee schedule. For 2019, CMS has relaxed documentation requirements to reduce the burden on providers.

- Providers will not be required to re-enter information about the patient’s chief complaint and any part of the history entered by the patient or a staff member, but must indicate in the patient record that the information was “reviewed and verified.”

- For established patient office/outpatient visits, providers may simply document changes (or pertinent items that have not changed) since the last visit when relevant information is already contained in the medical record. They will no longer be required to re-record the defined list of required elements if there is evidence they have reviewed the information previously recorded and updated it as necessary and indicated they have done so.

- Providers will no longer be required to document the medical necessity of a home visit in lieu of an office visit when reporting codes 99341 – 99350.

- Teaching physicians will no longer need to duplicate notations in the medical record that have been previously entered by residents or other members of the medical team. NOTE: further clarity may be prudent before any changes are made in this area as this may conflict with Physicians at Teaching Hospitals (PATH) guidelines.

E/M Beyond 2019

E/M documentation burdens will continue to be reduced in 2021. Providers will be able to choose to document office/outpatient visits Levels 2 through 5 using medical decision-making or time as the key documentation requirement instead of the 1995 and 1997 documentation guidelines for Evaluation and Management services. CMS intends to maintain a separate payment rate for level 5 visits to better account for the care and needs of complex patients.

For E/M office/outpatient level 2 through 4 visits, when using Medical Decision Making or current 1995 and 1997 documentation guidelines framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare would require information to support a level 2 E/M office/outpatient visit code for history, exam and/or medical decision-making.
When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the patient (typical CPT time for code reported, plus any extended/prolonged time).

CMS believes these policies will allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary.

In 2021 CMS will implement the major revision proposed for 2019 - collapsing E/M payment rates for office visit levels 2 through 4 to a single payment rate structure for both established patient visit codes 99212 – 99214 and new patient visit codes 99202 – 99204.

NOTE - CMS used 5 years of claims data utilization rates when developing the estimated payments proposed for 2021.

To offset reduced reimbursement from the bundled payment rates in 2021, CMS plans to offer an add-on code for extended visits to account for high-duration encounters corresponding to Level 2 through 4 visits. Add-on codes will be offered for primary care visits and for certain types of non-procedural specialized medical care.

NOTE: CMS intends to engage in further discussions with the public to potentially further refine the policies for CY 2021. After consideration of concerns raised by commenters in response to the proposed rule, CMS is not finalizing aspects of the proposal that would have:

1) reduced payment when E/M office/outpatient visits are furnished on the same day as procedures;

2) established separate coding and payment for podiatric E/M visits;

3) standardized the allocation of practice expense RVUs for the codes that describe these services.

Source: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/PFS-Federal-Regulation-Notices-Items/CMS-1693-F.html