MEDDATA SERVICE BUREAU | MEDTRON SOFTWARE INTELLIGENCE

080618 NEWS BLAST

ATTN: ALL PROVIDERS

DRASTIC
Evaluation & Management (E&M) (99201-99215) Changes in the 2019 Federal Register Proposed Rule

According to the 2019 Medicare Physician Fee Schedule rule proposed on July 27, 2018 by the Centers for Medicare and Medicaid Services (CMS), CMS suggests that they are proposing many new changes to E&M codes to 'lighten the burden on providers'. In the proposed rule, CMS states:

> *"As we have explained in prior rulemaking, we believe that the coding, payment, and documentation requirements for E&M visits are overly burdensome and no longer aligned with the current practice of medicine. We believe the current set of 10 CPT codes for new and established office-based and outpatient E&M visits and their respective payment rates no longer appropriately reflect the complete range of services and resource costs associated with furnishing E&M services to all patients across the different physician specialties, and that documenting these services using the current guidelines has become burdensome and out of step with the current practice of medicine.."*

Providers need to ACT NOW!!
This rule is only open for comment until
September 10, 2018.

Read the summaries below and the proposed CMS rule at https://www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions and let your voice be heard to stop this reduction in payments and other proposed changes.
When submitting your comments, **please refer to file code CMS-1693-P**.

- Electronically – go to http://www.regulations.gov, follow the "Submit a comment" instructions.
- Regular mail – mail written comments to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1693-P, P.O. Box 8016, Baltimore, MD 21244-8016.
- Express/Overnight mail – send written comments to: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS-1693-P, Mail Stop C4-26-05, 7500 Security Blvd, Baltimore, MD 21244-1850

MGMA Louisiana is asking providers to assist in evaluating the impact of these proposed changes and helping MGMA advocate on behalf of medical group practices by sharing your feedback on these proposals. Fill out a brief comment form located at: https://www.surveymonkey.com/r/GD8K9KX?utm_campaign=government-affairs&utm_medium=email&utm_source=7.18.18%20Washington%20Connection&elqEmailId=7311

UPCOMING WEB TRAININGS:

NAMAS, a division of Doctors Management, LLC, is offering a complimentary webinar training
CMS Proposed E&M Changes, Wednesday, August 8, 1 pm Central (2 pm EST)
Register: https://register.gotowebinar.com/register/7599988590574593026

SINGLE FEE AND REDUCED WRVU FOR NEW/ESTABLISHED ENCOUNTERS:

CMS is proposing to assign the same Relative Value Units (RVUs) to the level 2 through 5 Evaluation & Management (E&M) codes, which in turn creates the same payment amount for each of these codes and create new add-on codes to better capture the differential resources involved in furnishing certain types of E&M visits. CMS is further proposing to change the documentation requirements for E&M levels such that practitioners have the choice to use the 1995 guidelines, 1997 guidelines, time, or Medical Decision Making (MDM) to determine the E&M level.
CMS is suggesting a single payment rate and WRVU of:

Code:	Payment:	WRVU:
New Patient level 1 code 99201	$ 44.00	0.48
New Patient codes 99202-99205	$ 135.00	1.90
Established Patient level 1 code 99211	$ 24.00	0.18
Established Patient codes 99212-99215	$ 93.00	1.22

According to data listed in the proposed rule, much of the change will impact utilization of higher level codes for established office codes 99213 and 99214, which comprised 89% of allowed charges for the 99211-99215 series in 2016. Specifically, code 99214, which would face a $16 (~15%) pay cut under the proposal, accounted for 50% of allowable charges among the five established visit codes in 2016. The new patient codes 99203 and 99204 comprised 32% and 44%, respectively, of allowable charges in 2016.

Per Table 21-Unadjusted Estimated Specialty Impacts of Proposed Single RVU Amounts for Office/Outpatient E&M 2-5 Levels of the Proposed Rule, below shows some of the specialties CMS believes will have the greatest impact by the proposed rules.

Specialty	Allowed charges (in millions)	Estimated potential impact of valuing levels 2-5 together
Hand Surgery	$ 202	+6%
Otolaryngology*	1,220	+5%
Orthopedic Surgery	3,815	+4%
Obstetrics/Gynecology*	664	<+3%
Physician Assistant	2,253	<+3%
Cardiology*	6,723	<+3%
Geriatrics	214	-4%
Rheumatology*	559	-7%
Neurology*	1,565	-7%
Hematology/Oncology*	1,813	-7%
Endocrinology*	482	-10%

* An Add-On code is allowed with each patient visit by specialists WRVU: 0.25

Providers can estimate the impact on their practice by using the below compare of the current LA Medicare fee schedule rates and WRVUs to the proposed rates and WRVUs. Multiply the "Difference in F/S and WRVU" by your "Usage" counts of each CPT to estimate the 'Loss/Gain in F/S and WRVU'.

Code	2018 LA Medicare Area 99 F/S	Current WRVU	*Proposed F/S (Nat'l Avg)*	*Proposed WRVU*	Difference in: F/S	Difference in: WRVU	Usage	Loss/Gain in: F/S	Loss/Gain in: WRVU
99201	$ 42.75	0.48	*$ 44.00*	*0.48*	$ 1.25	0.00	x ____ =	_____	0.00
99202	$ 72.38	0.93	*$ 135.00*	*1.90*	$ 62.62	0.97	x ____ =	_____	_____
99203	$ 104.85	1.42	*$ 135.00*	*1.90*	$ 30.15	0.48	x ____ =	_____	_____
99204	$ 160.84	2.43	*$ 135.00*	*1.90*	$ (25.84)	(0.53)	x ____ =	_____	_____
99205	$ 202.95	3.17	*$ 135.00*	*1.90*	$ (67.95)	(1.27)	x ____ =	_____	_____
99211	$ 20.32	0.18	*$ 24.00*	*0.18*	$ 3.68	0.00	x ____ =	_____	0.00
99212	$ 42.00	0.48	*$ 93.00*	*1.22*	$ 51.00	0.74	x ____ =	_____	_____
99213	$ 70.51	0.97	*$ 93.00*	*1.22*	$ 22.49	0.25	x ____ =	_____	_____
99214	$ 104.30	1.50	*$ 93.00*	*1.22*	$ (11.30)	(0.28)	x ____ =	_____	_____
99215	$ 141.19	2.11	*$ 93.00*	*1.22*	$ (48.19)	(0.89)	x ____ =	_____	_____
GCG0X♦	N/A	N/A	*$ 13.70*	*0.25*	$ 13.70	0.25	x ____ =	_____	_____

♦*For HCPCS GCG0X usage, use the sum of usage for CPT 99201-99215. If PCP, use HCPCS GPC1X at F/S=$5.71, WRVU = 0.07.*

PROPOSED UPDATES TO E&M DOCUMENTATION:

E&M visits comprise approximately 40% of allowed charges for Professional Fee for Service (PFS) services, and office/outpatient E&M visits comprise approximately 20% of allowed charges for PFS services. 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.

CMS has a longstanding instruction that practitioners may use either the 1995 or 1997 versions of the E&M guidelines to document E&M visits billed to Medicare. This year, CMS is including their proposed E&M documentation changes in the proposed rule as listed below and are asking for public comment *(see above on how to add comments to proposed rule)*.

- CPT 99201-99215: Proposing to eliminate the rule stating that Medicare Administrative Contractors (MACs) may not pay two E&M office visits billed by a physician (or physician of the same specialty from the same group practice) for the same beneficiary on the same day unless the physician documents that the visits were for unrelated problems in the office, off campus-outpatient hospital, or on campus-outpatient hospital setting which could not be provided during the same encounter.

- CPT 99201-99215: Proposing to allow practitioners to choose, as an alternative to the current framework specified under the 1995 or 1997 guidelines, Medical Decision Making (MDM) as a basis to determine the appropriate level of E&M visit.
  - Allows different practitioners in different specialties to choose to document the factor(s) that matter most given the nature of their clinical practice.
  - Would reduce the impact Medicare may have on the standardized recording of history, exam and MDM data in medical records, since practitioners could choose to no longer document many aspects of an E&M visit that they currently document under the 1995 or 1997 guidelines for history, physical exam and MDM.
    - Documentation would need to meet minimum documentation standard where, for the purposes of PFS payment for an office/outpatient E&M visit, practitioners would only need to meet documentation requirements currently associated with a level 2 visit for history, exam and/or MDM (except when using time to document the service).

- CPT 99201-99215: Proposing to allow practitioners to choose, as an alternative to the current framework specified under the 1995 or 1997 guidelines, time as a basis to determine the appropriate level of E&M visit.
  - The typical time for the proposed new payment for E&M visit levels 2-5 has not been determined.
    - Three options are proposed for calculating time requirements based on the new payment system:
      - Set time for levels 2-5 at 31 minutes for an established patient and 38 minutes for a new patient.
      - Use units, i.e., a unit of time is attained when the mid-point is passed, such that CMS would require documentation that at least 16 minutes for an established patient (more than half of 31 minutes) and at least 20 minutes for a new patient (more than half of 38 minutes) were spent face-to-face by the billing practitioner with the patient.
      - Require documentation that the typical time for the CPT code that is reported was spent face-to-face by the billing practitioner with the patient. For example, a practitioner reporting CPT 99212 would be required to document having spent a minimum of 10 minutes, and a practitioner reporting CPT 99214 would be required to document having spent a minimum of 25 minutes.
  - The amount of time personally spent by the billing practitioner face-to-face with the patient could be used to document the E&M visit regardless of the amount of counseling and/or care coordination furnished as part of the face-to-face encounter.
  - Time requires the practitioner to document the medical necessity of the visit and show the total amount of time spent by the billing practitioner face-to-face with the patient.
  - When a practitioner chooses to document using time and also reports prolonged E&M services, we would require the practitioner to document that the typical time required for the base or “companion” visit is exceeded by the amount required to report prolonged services.

- CPT 99201-99215: Current guidelines state that a Review of Systems (ROS) and/or a pertinent past, family, and/or social history (PFSH) obtained during an earlier encounter does not need to be re-recorded if there is evidence that the physician reviewed and updated the previous information.
    - CMS is proposing to simplify further such that practitioners would only be required to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a defined list of required elements such as review of a specified number of systems and family/social history.

- CPT 99201-99215: Propose that for both new and established patients, practitioners would no longer be required to re-enter information in the medical record regarding the chief complaint and history that are already entered by ancillary staff or the beneficiary. The practitioner could simply indicate in the medical record that they reviewed and verified this information.

- CPT 99341-99350: Proposing to remove the requirement that the medical record must document the medical necessity of furnishing the visit in the home rather than in the office.

OTHER PROPOSED CHANGES AND NEW CODES IMPACTING PROVIDERS:

Reduction in Payment for Services Furnished on the Same Day as an E&M with Modifier 25
Using the surgical Multiple Procedure Payment Reduction (MPPR) as a template, CMS is proposing to reduce payment by 50% for the least expensive procedure or visit that the same physician (or a physician in the same group practice) furnishes on the same day as a separately identifiable E&M visit, currently identified on the claim by an appended modifier -25 or -57.

CMS is particularly concerned that when a standalone E&M visit occurs on the same day as a 0-day global procedure, there are significant overlapping resource costs that are not accounted for. We believe that separately identifiable visits occurring on the same day as 0-day global procedures have resources that are sufficiently distinct from the costs associated with an E&M visit.

**Deployed as part of the single fee/WRVU for New/Established patient concept.*

***New Add-On Code to Recognize Additional Relative Resources for Primary Care Services**
CMS is proposing an add-on code, HCPCS code GPC1X, which can be reported for other forms of face-to-face care management, counseling, or treatment of acute or chronic conditions not accounted for by other coding. HCPCS code GPC1X would be billed in addition to the E&M visit for an established patient when the visit includes primary care services.

While CMS expects that this code will mostly be utilized by the primary care specialties, such as family practice or pediatrics, other certain specialists such as an OB/GYN or a cardiologist may also function as primary care practitioners. CMS intends for this G-code to account for the resource costs of performing primary care visits, regardless of Medicare enrollment specialty, and is 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 this G-code may be billed alongside the proposed new code for prolonged E&M services

- 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
  Proposal: WRVU = 0.07, Physician time = 1.75 minutes, approximate F/S rate = $5.71

NOTE: CMS is proposing that practitioners in the specialty of psychiatry would not use this add-on code because psychiatrists may utilize CPT 90785 to describe work that might otherwise be reported with a level 4 or level 5 E&M visit.

***New Add-On Codes to Recognize Additional Relative Resources for Specialty Professionals**
CMS is proposing to create a HCPCS G-code to be reported with an E&M service to describe the additional resource costs for specialty professionals for whom E&M visit codes make up a large percentage of their overall allowed charges and whose treatment approaches are generally reported using the level 4 and level 5 E&M visit codes rather than procedural coding.

- GCG0X - Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care
  Add-on code, list separately in addition to an evaluation and management visit
  Proposal: WRVU = 0.25, Physician time = 8.25 minutes, approximate F/S rate = $13.70

NOTE: CMS is proposing that practitioners in the specialty of psychiatry would not use this add-on code because psychiatrists may utilize CPT 90785 to describe work that might otherwise be reported with a level 4 or level 5 E&M visit.

New Code for Prolonged Services
Citing the hour-long threshold of prolonged service code 99354 as an "impediment" to reporting it, CMS is proposing a new prolonged service code with a threshold of 30 minutes.

- GPRO1 - Prolonged evaluation and management 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]
  Proposal: WRVU = 1.17, Physician time = 30 minutes, approximate F/S rate = $67.41

New Code for Virtual Check-In
CMS is proposing to create a G-code, HCPCS code GVCI1 to facilitate payment for these brief communication technology-based services to encompass a broader array of communication modalities.

- GVCI1 - Brief communication technology based service, e.g. virtual check-in, by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, not originating from a related E&M service provided within the previous 7 days nor leading to an E&M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
  Proposal: WRVU = 0.25, Physician time = 5-10 minutes

New Codes for Superficial Radiation Treatment (SRT) Planning and Management
CMS is seeking comment on the possibility of creating multiple G-codes specific to services associated with SRT. These codes would be used separately to report services including SRT planning, initial patient simulation visit, treatment device design and construction associated with SRT, SRT management, and medical physics consultation; mirroring the coding of other types of radiation treatment delivery.

RESOURCES:

Part B News, July 23, 2018, Single-Fee E&M Pay Rates Poised to Take Over for New/Established Encounters: https://pbn.decisionhealth.com/

Federal Register: https://www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions

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