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Special Issue

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SPECIAL ISSUE

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All Medicare fees are par, office, national unless otherwise noted.

E/M payment changes

Single-fee E/M pay rates poised to take over for new, established encounters

CMS is proposing to flatten payments for office encounters, suggesting a single payment rate of \$93 for established office codes **99212-99215** and \$135 for new patient codes **99202-99205** instead of distinct rates for each service, according to the proposed 2019 Medicare physician fee schedule.

The compressed payment structure, which could take effect as early as Jan. 1, would impact hundreds of millions of E/M encounters and arrives as a corollary to CMS' proposal to tie up level 2 through 5 codes, for reporting purposes, in the same basket (*see*

(see E/M pay rates, p. 9)

E/M documentation changes

CMS floats multiple E/M documentation options to supplement current guidelines

The 20-plus-year reign of the current E/M documentation guidelines may be coming to an end, as CMS seeks to promote distinct elements of an office encounter, including medical decision-making or time, into more prominent positions, according to the proposed 2019 Medicare physician fee schedule.

Released July 12, the proposed rule would offer physician practices a large dose of flexibility in how they choose to record their office encounters, with CMS promoting multiple

(see E/M documentation changes, p. 11)

Prepare for Drastic E/M Changes



CMS' game-changing proposals could significantly impact practices' revenue as soon as Jan. 1. Take steps to get ahead of CMS' E/M changes and prepare your practice for success with our webinar, **Prepare for Huge E/M Changes: CMS' Game-Changing Payment, Documentation Proposals** on August 22.

Learn more: www.codingbooks.com/ympda082218.

Quality Payment Program

QPP in the PFS 2019: More patient, outcome focus; 'gold' quality measures; other changes

CMS shows it means business about outcome and patient-reported measures in the Quality Payment Program (QPP) and the merit-based incentive payment system (MIPS) section of the proposed 2019 Medicare physician fee schedule with measure changes that increase the focus in those areas. Other meaningful changes include a stripped-down, information-exchange-focused Promoting Interoperability category; new standards for small practices and low-volume exemptions; a proposed “tiered” quality scoring system; and more.

CMS states in the rule that it hoped to realize in QPP the goal stated in its Meaningful Measures initiative to “assess the core quality of care issues that are most vital to advancing our work to improve patient outcomes and patient-reported measures” (*PBN 12/11/17*). Its proposed quality measure changes back that up by adding four patient-reported outcome measures and two patient-reported process measures. The outcome measures are:

- Average change in functional status following lumbar spine fusion surgery,
- Average change in functional status following total knee replacement surgery,

- Average change in functional status following lumbar discectomy laminotomy surgery and
- Average change in leg pain following lumbar spine fusion surgery.

The two patient-reported process measures are:

- Zoster (shingles) vaccination and
- HIV screening.

The other new quality measures that bring the total to 10 are:

- Falls: Screening, risk-assessment, and plan of care to prevent future falls,
- Ischemic vascular disease use of aspirin or anti-platelet medication,
- Appropriate use of DXA scans in women under 65 years who do not meet the risk factor profile for osteoporotic fracture and
- Continuity of pharmacotherapy for opioid use disorder.

CMS proposes to remove 34 quality measures, all but five of which are process measures.

Other signs throughout the rule show CMS' focus on outcomes and patients. CMS also proposes, for example, that the Medicaid Promoting Interoperability program adopt the MIPS requirement that eligible providers (EPs) report at least one outcome measure or, if unavailable, a high-priority measure. And the agency is changing some measures in the Shared Savings Program to “place

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greater emphasis on outcome measures and the voice of the patient.”

“Patient-reported outcomes have never been in there in such a big way,” says Theresa Hush, CEO and co-founder of Roji Health Intelligence in Chicago.

Quality categories tiered by value

CMS proposes “a system where [quality] measures are classified as a particular value (gold, silver or bronze) and points are awarded based on the value of the measure.” Gold measures would include the outcome measures CMS says it’s trying to promote; composite measures, which are measures that have two measure components, such as the diabetes mellitus [DM] composite measure that combines the Diabetes: Hemoglobin A1c and Diabetes: Eye Exam measures; “measures that address agency priorities (such as opioids)”;

and the Consumer Assessment for Healthcare Providers and Systems (CAHPS) for MIPS survey, considered “high value” because it collects patient experience data. The gold measures would earn the most points. Fewer points would be granted to silver measures, which CMS describes as “process measures that are directly related to outcomes and have a good gap in performance” and topped-out outcome measures; the rest — “lower value measures, such as standard-of-care process measures or topped-out process measures” — would be ranked bronze.

More cost, less quality in MIPS score

Quality is reduced in the proposed rule from 50% of total MIPS score to 45%, while cost rises from 10% to 15%. CMS cites the Medicare Access and CHIP Reauthorization Act (MACRA) mandate to bring cost up to 30% of the total score by 2021 as its reason for the rise. Improvement activities stay at 15% of the MIPS score, and promoting interoperability stays at 25%. Providers will need to report at least six quality measures including at least one outcome measure, with exceptions. Practices still must report for 60% of their patients to meet “data completeness” for full scoring, but the “exceptional performance threshold” for extra bonus money kicks in at 80 rather than the current 70 points. And overall they have to rack up at least 30 points to meet the “performance threshold,” rather than the current 15.

In addition to the total-per-capita-cost and Medicare-spending-per-beneficiary measures with which CMS has been calculating your MIPS cost scores, the agency will add

eight episode-based measures if CMS finalizes its proposals. Cost for these are calculated using Medicare Parts A and B fee-for-service claims data, payment-standardized and risk-adjusted, and attributed providers’ costs will be compared with them. The proposed measures are:

- Elective outpatient percutaneous coronary intervention (PCI);
- Knee arthroplasty;
- Revascularization for lower extremity chronic critical limb ischemia;
- Routine cataract removal with intraocular lens (IOL) implantation;
- Screening/surveillance colonoscopy;
- Intracranial hemorrhage or cerebral infarction acute;
- Simple pneumonia with hospitalization; and
- ST-elevation myocardial infarction (STEMI) with percutaneous coronary intervention (PCI).

Promoting Interoperability changes

The former Advancing Care Information (ACI) category has made other changes that live up to its new name, Promoting Interoperability, but make it harder for providers to achieve high scores. The 22 measures currently in the category would be reduced to these 11:

- Support electronic referral loops by sending health information measure, formerly the send a summary of care measure;
- Support electronic referral loops by receiving and incorporating health information, formerly the request/accept summary of care and clinical information reconciliation measures;
- e-Prescribing;
- Provide patients electronic access to their health information;
- Immunization registry reporting;
- Electronic case reporting;
- Public health registry reporting;
- Clinical data registry reporting;
- Syndromic surveillance reporting;
- Query of prescription drug monitoring program (PDMP), a bonus measure; and
- Verify opioid treatment agreement, a bonus measure.

The point totals are very high — the access measure is 40 points and the referral-loop measures are 20 points apiece — which leaves less margin for error than the previous menu.

“There are fewer paths to get [to a full Promoting Interoperability score],” says Tom Lee, CEO of Ignite SA in Chicago. “Under ACI, there were multiple optional performance measures and bonuses. ... [In Promoting Interoperability,] you really have to get maximum performance in all categories to hit 100.”

“It’s fewer measures but more difficult,” says Ida Mantashi, senior product manager at electronic health record (EHR) company Modernizing Medicine in Boca Raton, Fla. “The older measures, providers were comfortable with them.” Also, the focus on two-way information exchange may be a challenge for some providers. For example, specialists who are used to receiving but not sending referrals will have to partner with tech-savvy providers and send data to them if they want to report the high-scoring “loop” measures, says Mantashi.

Also, providers no longer have “transitional” measures because in 2019, all participants must be on 2015 certified EHR technology (CEHRT) — not the 2014 version, says Shane Peng, M.D., chief clinical services officer at IKS Health in New York City. And if they aren’t on 2015 CEHRT, they score zero in this category.

Welcome, new MIPS eligibles

CMS proposes to add physical therapists, occupational therapists, clinical social workers and clinical psychologists as MIPS-eligible providers in 2019. It also will consider adding qualified speech-language pathologists, qualified audiologists, certified nurse-midwives, registered dietitians and nutrition professionals to MIPS but must first finalize the quality measures to know whether those providers would have enough measures (six) to report.

If you’re in one of the new categories of providers and are reporting for the first time, CMS proposes to automatically assign you a 0% weighting for the Promoting Interoperability performance category, and will add that 25% to your quality measures weight, making it 75%.

QPP changes for small practices

CMS wants to give practices with 15 or fewer providers a break, and the biggest one for some who don’t want to budget for a registry is that they will be the only providers allowed to use Medicare Part B claims submission type to report quality measures in 2019. If

your organization is 16 providers or more, it cannot use claims-based reporting.

CMS also is keeping the small-practice bonus available to clinicians in practices of 15 or fewer clinicians — but only in the quality category. The agency says small-practice providers can apply for a significant hardship exception for the Promoting Interoperability performance. Improvement activities already have special small-practice rules, and the cost category does not require any reporting from them. Thus, every small-practice clinician who submits at least one quality measure in 2019 gets an extra three points in the numerator of the quality performance category.

Small practice status is determined by CMS assessment of your claims data for a 12-month period spanning the last four months of a calendar year two years prior to the performance period and the first eight months of the next calendar year — so, for 2019, that’s your performance from September 2017 through August 2018.

New low-volume metric, opt-in option

CMS proposes to stick with this year’s 200-patient, \$90,000 allowed charges standard for the MIPS low-volume threshold — but also to exempt providers with “200 or fewer covered professional services furnished to Part B-enrolled individuals.”

And if you’re excluded from MIPS for low volume but still want to report, good news — you can opt in to participate voluntarily in MIPS if you exceed at least one, but not all three, of the low-volume threshold criteria. For example, a practice that furnished more than 200 covered professional services to its more-than-200 Part B patients could opt in if it billed less than \$90,000 in charges; but if both that practice’s number of patients and services dropped under 200, it could not opt in. Alternatively, if it still had the 200-plus patients and services and its charges ticked over \$90,000, it would lose its low-volume exemption and be required to participate in MIPS.

To opt in, providers would “make an election via the Quality Payment Program portal by logging into their account and simply selecting either the option to opt-in (positive, neutral or negative MIPS adjustment) or to remain excluded and voluntarily report (no MIPS adjustment).” Once you do it, though, you can’t change status until the next performance year.

(continued on p. 6)

*Benchmark of the week***Single-rate E/M pay structure creates winners, losers under proposed fee schedule**

Some specialties, including podiatry and dermatology, would see a significant pay increase for E/M services should CMS' proposal to group level 2 through 5 outpatient codes into one payment basket go into effect on Jan. 1, according to reimbursement estimates contained in the proposed 2019 Medicare physician fee schedule released July 12.

The proposal to group level 2 through 5 codes together, which is just one of an array of suggested changes that would impact E/M services, would essentially pay providers the same rate when reporting **99212** or **99215**, for example. The \$93 rate that CMS floated in the rule is higher than the current rate of \$74 for **99213** but below the \$109 fee for **99214**.

Switching to single-rate structure would result in "minimal change to overall payment" for the majority of specialties, including family practice providers, general surgeons and radiologists, according to the final rule. Six specialties would see at least a 4% increase in overall payments, while five specialties would lose at least 4%. Endocrinologists would fare the worst, with an estimated 10% loss in reimbursement, and oncologists, cardiologists and internal medicine providers would all see payment fall under the proposal. — *Richard Scott (rscott@decisionhealth.com)*

Estimated impact of proposed single RVU amounts for outpatient E/M level 2 to 5 codes

Specialty	Allowed charges (in millions)	Projected impact of E/M payment changes	Specialty	Allowed charges (in millions)	Projected impact of E/M payment changes
Podiatry	\$2,022	12%	Interventional radiology	\$362	Minimal change
Dermatology	\$3,525	7%	Multispecialty clinic/Other	\$141	Minimal change
Hand surgery	\$202	6%	Neurosurgery	\$812	Minimal change
Otolaryngology	\$1,220	5%	Nurse practitioner	\$3,586	Minimal change
Orthopedic surgery	\$3,815	4%	Ophthalmology	\$5,542	Minimal change
Colon and rectal surgery	\$168	4%	Pathology	\$1,151	Minimal change
Obstetrics/gynecology	\$664	Up to 3% increase	Physical medicine	\$1,120	Minimal change
Optometry	\$1,276	Up to 3% increase	Psychiatry	\$1,260	Minimal change
Physician assistant	\$2,253	Up to 3% increase	Radiation oncology	\$1,776	Minimal change
Plastic surgery	\$387	Up to 3% increase	Radiology	\$4,898	Minimal change
Allergy/immunology	\$240	Minimal change	Urology	\$1,772	Minimal change
Anesthesiology	\$1,995	Minimal change	Vascular surgery	\$1,132	Minimal change
Cardiac surgery	\$313	Minimal change	Cardiology	\$6,723	Up to 3% decrease
Chiropractor	\$789	Minimal change	Internal medicine	\$11,173	Up to 3% decrease
Critical care	\$334	Minimal change	Nephrology	\$2,285	Up to 3% decrease
Emergency medicine	\$3,196	Minimal change	Pediatrics	\$64	Up to 3% decrease
Family practice	\$6,382	Minimal change	Pulmonary disease	\$1,767	Up to 3% decrease
Gastroenterology	\$1,807	Minimal change	Geriatrics	\$214	-4%
General practice	\$461	Minimal change	Rheumatology	\$559	-7%
General surgery	\$2,182	Minimal change	Neurology	\$1,565	-7%
Infectious disease	\$663	Minimal change	Hematology/oncology	\$1,813	-7%
Interventional pain mgmt	\$839	Minimal change	Endocrinology	\$482	-10%

Source: Proposed 2019 Medicare physician fee schedule

(continued from p. 4)

CMS leans on QCDRs

CMS received 40% more measure submissions for review by qualified clinical data registries (QCDRs) in 2018 than in 2017, and it's worried that some QCDRs submitting these "have a predominantly technical background with limited understanding of medical quality metrics or the process for developing quality measures" and "have not undergone the same consensus development, scientific rigor and clinical assessment" in developing measures as "specialty societies and other entities with clinical expertise" who run their own QCDRs.

"I assume some were very low-bar entries, such as 'I touched the patient!'" jokes Jennifer Searfoss, Esq., founder of Ashburn, Va.-based SCG Health.

Therefore, CMS proposes, starting in the 2020 performance/2022 payment year, to modify the definition of a QCDR to say they "must have clinical expertise in medicine and quality measure development" and to require QCDRs to have at least 25 participants in the year prior to the performance period to submit data to the QCDR for quality improvement purposes.

CMS also will more or less force QCDRs to share their measures with other QCDRs — something they currently do voluntarily and sometimes charge money for (*PBN 6/28/18*). Declaring that "once a QCDR measure is approved for reporting in MIPS, it should be generally available for other QCDRs to report on for purposes of MIPS without a fee for use," starting in 2019 CMS proposes requiring QCDRs "to enter into a license agreement with CMS permitting any approved QCDR to submit data on the QCDR measure (without modification) for purposes of MIPS and each applicable MIPS payment year." Thus, QCDRs that wish to use measures developed and used by other QCDRs would no longer have to negotiate with the developer to use those measures themselves, nor could that developer refuse to let them use it.

MA demo may boost your pay

No big changes are proposed in the advanced alternative payment model (APM) part of the rule — the 8% revenue-based nominal amount for entry will remain in place through 2024 at least. But CMS proposes a demo that would give provider groups with a lot of Medicare Advantage (MA) billings and risk

that resembles that of an advanced APM a chance to be exempt from MIPS — and, CMS says, for other providers to get larger positive payment adjustments.

Under a new Medicare Advantage Qualifying Payment Arrangement Incentive (MAQI) demonstration program, providers who "participate sufficiently in Medicare Advantage (MA) arrangements that are similar to Advanced APMs" via their Medicare Advantage organizations (MAOs) would not have to participate in regular MIPS. Requirements would "be the same as the Other Payer Advanced APM criteria under QPP for the applicable year," says the rule — mainly, that they "bear more than nominal financial risk." Currently, that means total risk of 3% if measured by expenditures and 8% if measured by revenue. Clinicians would also have to meet a "combined threshold for participation in Qualifying Payment Arrangements and Advanced APMs," measured either by patient count (for 2019, 35%) or payment amount (for 2019, 50%).

The clinicians and their MAOs would have to submit materials in evidence to CMS, including the name of the payer and payment arrangement, a description of how the payment arrangement meets the requirements and documentation of the payment arrangement (e.g., contracts). The application form is here: <https://innovation.cms.gov/initiatives/maqi/>.

CMS says that because this demo would "exclude certain clinicians from the pool of MIPS-eligible clinicians for which the MIPS payment adjustments are calculated," the demo "may have the effect of changing the aggregate amount of MIPS payment adjustments received by MIPS-eligible clinicians to whom the waivers do not apply" — that is, of increasing their share of the take.

More changes to come?

CMS will take comments on the proposed rule via www.regulations.gov until Sept. 10.

"I'm hesitant to consider this the final version because last year there was a significant difference between the proposed and final [MIPS] rules," says Hush — for example, there was that 10% cost category charge no one expected (*PBN blog 11/2/17*). If former rules are any indication, we have four months to find out. — Roy Edroso (redroso@decisionhealth.com)

*E/M payment changes***CMS proposes multi-service reduction for office procedures, E/Ms**

Clinicians could see a cut to their Medicare reimbursement next year when an E/M visit is reported the same day as an office procedure.

CMS proposes to apply a multiple-service payment adjustment when “E/M visits and procedures with global periods are furnished together,” similar to its long-standing multiple-procedure payment reduction (MPPR) for surgical and some imaging services, the agency states in the proposed 2019 Medicare physician fee schedule, released July 12.

Under the proposal, when an E/M is reported on the same date as an office procedure, Medicare would reduce payment by 50% for the least expensive service provided. In some cases, it could be the E/M service — for example, if reported with a higher-valued procedure such as a sacroiliac joint injection (\$163). In other cases, the reduced payment could be for the procedure, such as a trigger point injection (\$55) next year. The proposal appears to apply to office-based services when modifier **25** (Significant, separately identifiable E/M service) would be appended to the E/M code.

Physicians take a dim view of the proposal. “From our point of view, often the E/M has to do with something totally different than the procedure being done that day,” so a blanket 25 modifier reduction would be the wrong approach, explains Dale Blasier, M.D., vice chair of the American Academy of Orthopaedic Surgeons’ Coding Coverage & Reimbursement Committee.

Medicare instead should require the surgeon to link the E/M service and procedure codes to separate diagnosis codes to be paid, he says.

Note that CMS also proposes to reimburse level 2 to 5 established-patient E/M codes at a single flat rate of \$93 in the office setting (*see story, p. 1*).

The proposed multi-service reduction would apply a 50% cut to office visits reported with one of dozens of procedures that have a reimbursement rate higher than \$93, according to *Part B News* analysis of 2016 Medicare utilization data, which is the latest available.

For example, a separate E/M would be subject to a cut when reported with complex wound repair

code **13132** (\$475), cystoscopy code **52000** (\$190) and destruction of skin lesions code **17262** (\$174) (all fees par, not adjusted for locality).

Conversely, you could see reimbursement for lower-value procedures cut in half when reported with an E/M, such as major joint arthrocentesis with ultrasound, code **20611** (\$93) and plantar digital nerve injection code **64455** (\$48).

Oddly, that could actually incentivize physicians to report E/M codes more often with lower-paying procedures, worries consultant Maxine Lewis, at Medical Coding and Reimbursement in Cincinnati.

“If they know they can get paid for it and the purpose of the visit was not strictly for the procedure, I think CMS is going to see a proliferation of these services,” she observes. “Physicians were very reluctant to report the 25 modifier. Now, are they giving them carte blanche to do it?”

Certain office procedure values reduced

The proposed policy is not the only way CMS is seeking to head off what it views as duplicative spending on E/Ms and office visits.

The agency also is proposing to reduce the work value of certain office procedure codes that are reported with E/M services at least 50% of the time.

“We believe that there is overlap between [an E/M and procedure] in some of the activities furnished during the preservice evaluation and post-service time,” CMS states in the proposed rule. Specifically, CMS states that it assumes that “at least one-third of the work time in both the preservice evaluation and post-service period is duplicative of work furnished during the E/M visit.”

Based on that, CMS is proposing lower work relative value units for these codes:

- **11755** (Biopsy of nail unit), which would reimburse at \$115 next year, compared with this year’s \$135,
- **20551** (Injection[s]; single Tendon origin-insertion), which would reimburse at \$54 next year, compared with \$62 this year and
- **29105** (Application of a long-arm splint), which would be priced at \$86 next year, compared with \$91 this year. — *Laura Evans, CPC* (levans@decisionhealth.com)

New, revised, deleted codes

Proposed rule provides an early look at next year's coding changes

You can expect 81 new codes, 27 deleted codes and more than a dozen revised CPT codes and HCPCS codes in 2019, according to the proposed 2019 Medicare physician fee schedule. In addition, CMS intends to shift the status of four E/M codes from bundled to active.

New services are flagged in the rule's Table 13: CY 2019 proposed work relative value units (RVUs) for new, revised and potentially misvalued codes. The new services — represented in the proposed rule by dummy codes that will not be used to report services — are mixed in with other codes CMS considered and the agency's proposed work RVUs for 2019. For example, the chart contains the proposed work RVUs for office/outpatient E/M visits (*see story, p. 1*).

The section on proposed valuation of specific codes for 2019 provides more details about the changes, including codes that will be deleted and revised.

E/M services

CMS has big plans for E/M services that go beyond the drive to flatten payments for office/outpatient services. For example, you'll see new CPT codes and HCPCS codes designed to cut down on the number of office visits.

CMS opens the door to electronic consult and referral services. Practices should take a look at the interprofessional telephone/Internet assessment and management codes that were introduced in 2014 (**99446-99449**). CMS intends to flip the four time-based codes from bundled to active status next year and restrict coverage to services performed in facilities. The existing codes “describe assessment and management services in which a patient's treating physician or other qualified healthcare professional requests the opinion and/or treatment advice of a physician with specific specialty expertise to assist with the diagnosis and/or management of the patient's problem without the need for the face-to-face interaction between the patient and the consultant,” CMS states. The existing codes will be updated to add communication via electronic health record (EHR). Reimbursement would be set as follows:

- 5-10 minutes (99446): \$18.38.

- 11-20 minutes (**99447**): \$36.05.
- 21-30 minutes (**99448**): \$54.43.
- 31 minutes or more (99449): \$72.81.

Watch for more guidance on two new CPT codes that will be added to this family and that Medicare intends to cover when performed in the facility setting next year. One will allow the treating clinician to bill for at least 30 minutes of services. The descriptor states “Interprofessional telephone/Internet/electronic health record referral service(s) provided by a treating/requesting physician or qualified health care professional, 30 minutes.” A second code will allow the consulting clinician to report a consult with a written report: “Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 or more minutes of medical consultative time.” Reimbursement for both codes would be \$26.67.

New payments for non-face-to-face services using technology. CMS proposes to pay starting Jan. 1 for “brief check-in services” in which a physician uses “communication technology” to determine whether an established patient needs an office visit and for review of patient-generated still or video images, such as a photo sent via text message.

The check-in services would receive a \$15.14 payment if they don't result in office visits, the rule states. If a patient does see the provider as a result of the call, the payment would be bundled into the office visit. The service is described in the rule with dummy code **GVC11** (Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can 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).

A \$12.98 payment for the remote evaluation of patient-generated still or video images would not include remote patient monitoring reported with CPT codes but would be used to determine whether an office visit is warranted. It's represented in the rule with HCPCS code **GRAS1** (Remote evaluation of recorded video and/or images

submitted by the patient [e.g., store and forward], including interpretation with verbal follow-up with the patient within 24 business hours, 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).

CMS seeks comment on several aspects of the proposals, from what types of communication technology are included to time limits for the services.

DIY chronic care management. Doctors and other qualified health care professionals will be reimbursed when they personally provide the care coordination work associated with **99490**. The descriptor calls for at least 30 minutes of work, compared with 20 minutes when performed by clinical staff: “Chronic care management services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month, with the following required elements: multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient, chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline; comprehensive care plan established, implemented, revised, or monitored.” Reimbursement would be set at \$74.26, compared with \$43.62 for the clinical staff code.

Podiatry E/Ms. Podiatrists will have two codes of their own to report E/M services if CMS goes through with its plans next year. One code would be used for new patients: “Podiatry services, medical examination and evaluation with initiation of diagnostic and treatment program, new patient.” Podiatrists would receive approximately \$102 for the service and \$67 for established patient visits.

Changes to substance use assessment codes. To boost utilization of these codes, CMS intends to add a new code with a lower time threshold: “Alcohol and/or substance (other than tobacco) abuse structured assessment (e.g., AUDIT, DAST), and brief intervention, 5-14 minutes.” The existing codes have thresholds of 15-30 minutes (**G3906**) and 30 minutes or more (**G3907**). But that’s not all. In the proposed rule, CMS observes that utilization for these services is relatively low, “which we believe is in part due to the service-specific documentation requirements for these codes.” The solution? Get rid of the additional requirements. “We believe that removing the additional

documentation requirements will also ease the administrative burden on providers.”

(This story continues online with coverage of changes in codes for the integumentary, musculoskeletal, cardiovascular, hemic and lymphatic, digestive and urinary systems plus radiology and medicine. Go to www.partbnews.com for more. If you need your login and password information, please contact Customer Service at customerservice@decisionhealth.com.)

E/M pay rates

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story, p. 1). The federal agency would offer separate payment for level 1 codes **99201** at \$44 and **99211** at \$24.

“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,” CMS states in the proposed rule.

Instead of adopting a new code set, the agency is attaching the same relative value units (RVUs) to the level 2 through 5 codes, which creates the same payment amount. Much of the change will impact utilization patterns of established office codes **99213** and **99214**, which comprised 89% of allowed charges for the 99211-99215 series in 2016, according to data contained in the proposed rule. Specifically, code 99214, which would face a \$16, or about 15%, pay cut under the proposal, accounted for 50% of allowable charges among the five established visit codes in 2016.

Among the new patient codes, 99203 and 99204 comprised 32% and 44%, respectively, of allowable charges in 2016. Practices billing the new rate for 99204 would see a 13% decrease in pay; yet those losses could be offset by a 23% gain for the new 99203 rate.

“Whether you ‘win’ or ‘lose’ in this rule depends entirely on your current E/M profile,” says Betsy Nicoletti, president of Medical Practice Consulting in Northampton, Mass. “Specialists who saw a lot of new patients at level 4 and 5 will probably lose. If you are a primary care physician who bills a lot of 99214s, your income may go down. But if you billed a lot of 99212s and 99213s, you’ll see a bump.”

Several specialty groups are expected to see a pay bump under the proposal, including orthopedic surgeons and dermatologists, although many may see a modest increase or decrease (*see benchmark, p. 5*). While the payment fallout remains a moving target, experts say that practices should get a reprieve from the threat of audits.

“E/M coding risk has been a significant risk to practices and providers and increasingly so over the years,” says Valerie Rock, senior manager with consultancy PYA in Atlanta. “Flattening the rate and the documentation requirements to a level 2 will primarily reduce the risk of a Medicare overpayment to the practice or facility since the likelihood of not meeting the documentation requirements of a level 2 is low.”

CMS was explicit in its intent to back off from chart reviews: “We believe that eliminating the distinction in payment between visit levels 2 through 5 will eliminate the need to audit against the visit levels, and therefore, will provide immediate relief from the burden of documentation,” the agency states.

When it comes to code choice, how such a proposal would play out in practice remains to be seen, although CMS anticipates that providers would continue to code to the appropriate level even under a single-rate pay structure. “We expect that, for record keeping purposes or to meet requirements of other payers, many practitioners would continue to choose and report the level of E/M visit they believe to be appropriate under the CPT coding structure,” the rule states.

Find new add-on E/M codes

To supplement E/M pay rates for primary care providers, CMS is proposing an add-on code that the agency expects practices to report “with every primary care-focused E/M visit for an established patient,” the rule states. The code, with the full description below, would tack on an extra \$5.41 per encounter, according to RVU data contained in the rule.

- **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]).

The agency says that the placeholder GPC1X code is meant “to capture the additional resource costs” of primary care services and that it is designed “to mitigate potential payment instability that could result from our adoption of single payment rates that apply for E/M code levels 2 through 5.”

Also, 10 specialists could take advantage of an add-on code designed for providers who report a high percentage of E/M encounters. Paying about \$13.70, the specialty-specific add-on code is:

- **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

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code, list separately in addition to an evaluation and management visit]).

Prolonged services reportable at 30 minutes

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]).

The new code is projected to pay about \$67.41 per encounter, according to RVU data in the rule. But, as written, the proposed code may not solve the problem CMS has identified; the time threshold for 99354 is 30 minutes, and HCPCS codes do not follow the halftime rule of most time-based CPT codes. — *Richard Scott (rscott@decisionhealth.com) with additional reporting by Julia Kyles, CPC (jkyles@decisionhealth.com)*

Office visit E/M pay rates proposed for 2019

Take note of how CMS' proposals for a single reimbursement rate for levels 2 through 5 E/M office visits would affect your revenue (*see story, p. 1*). All fees listed are national averages for nonfacility, Medicare-participating providers.

Proposed payment rates for new patient visits

Code	Non-facility rate (in 2018 \$)	Revised rate (in 2018 \$)
99201	\$45	\$44
99202	\$76	\$135
99203	\$110	\$135
99204	\$167	\$135
99205	\$211	\$135

Proposed payment rates for established patient visits

Code	Non-facility rate (in 2018 \$)	Revised rate (in 2018 \$)
99211	\$22	\$24
99212	\$45	\$93
99213	\$74	\$93
99214	\$109	\$93
99215	\$148	\$93

Source: Proposed 2019 Medicare physician fee schedule

E/M documentation changes

(continued from p. 1)

documentation frameworks that would capture the work related to office-based E/M codes **99201-99215**.

However, don't cast the current guidelines to the wayside entirely. The proposed rule would allow practices to continue to use the 1995 and 1997 guidelines to establish levels of care — although you may be using them in a truncated format where guidelines for meeting levels 3 to 5 codes exist but would no longer be required to support code choice.

The rule would allow practices to opt to use the single elements of medical decision-making or time to support their E/M encounters. In a shift that is “intrinsically related” to the sweeping payment changes to E/M services also contained in the 1,473-page proposed rule, the documentation proposals are intended to serve as “an alternative to the current framework specified under the 1995 or 1997 guidelines,” CMS states (*see story, p. 1*).

Yet the freewheeling nature of the proposal may leave practices in a bind. “If the E/M documentation guidelines include a lot of flexibility and options and are not included in a defined document or manual, the commercial and other government payers may have difficulty in adopting them,” says Valerie Rock, CPC, senior manager with consultancy PYA in Atlanta.

Level 2: The new (proposed) baseline

CMS is proposing a new baseline for documentation standards: Providers would select the current 1995 or 1997 guidelines or use medical decision-making on its own. They must meet the documentation requirements currently associated with a level 2 visit.

“For purposes of our medical review ... Medicare would only require documentation to support the medical necessity of the visit and the documentation that is associated with the current level 2 CPT visit code,” CMS states in the proposed rule. Under the proposal, you may have a complex patient whose visit qualifies as a level 4 or 5 E/M code, but your documentation would have to meet only level 2 requirements to meet CMS' standards.

Given the disconnect, that could leave practices wading into a vast gray area.

“I think CMS is being a little fast and loose, where providers can use CPT [codes] but not meet the documentation

requirements,” says Jugna Shah, MPH, president and founder of Nimit Consulting in Washington, D.C.

Here’s an example of what level 2 documentation requirements would look like in practice: Under the current guidelines, a provider could include a problem-focused history without a review of systems or a past, family or social history; a limited examination; and straightforward medical decision-making and risk (or data review). To document solely using medical decision-making, the provider would have to document straightforward medical decision-making and risk (or data review).

“Often, the most stringent guidelines are published by Medicare,” Rock says. “This would potentially make Medicare the least stringent and would not eliminate the [practice’s] risk for commercial payer issues if the same guidelines were not adopted.”

CMS did not heed some commenters’ suggestions that the agency revise the medical decision-making element before allowing providers to use it as a standalone pillar of documentation. “We propose to allow practitioners to rely on [medical decision-making] in its current form to document their visit and are soliciting public comment on whether and how guidelines for [medical decision-making] might be changed in subsequent years,” CMS states.

Time also a deciding factor

The agency also is proposing to allow providers to base their E/M encounters entirely on time — specifically, the “amount of time personally spent by the billing practitioner face-to-face with the patient,” according to the rule.

CMS is seeking comment on what the time threshold should be for levels 2 through 5 E/M codes. The typical time, or weighted average, of an established office visit is 31 minutes, and for a new patient it’s 38 minutes, according to CMS data, and the agency says it could use those standards. The agency also notes that it could adopt the CPT policy that counts a unit of time as fulfilled when the mid-point is passed. That would be 16 minutes for an established visit when using the typical time stated above. CMS says it could also use the typical times published in the CPT book (e.g., 25 minutes for **99214**). The agency is seeking comment on time-based reporting.

According to CMS, commenters have consistently bemoaned that “the guidelines are too complex, ambiguous, fail to meaningfully distinguish differences among code levels and are not updated for changes in technology, especially electronic health record (EHR) use.”

Opening up multiple options for meeting documentation standards would “allow different practitioners in different specialties to choose to document the factor(s) that matter most given the nature of their clinical practice,” CMS says.

“Different choice is always a good thing,” says Maxine Lewis, president of Medical Coding and Reimbursement in Cincinnati.

Lewis believes the emergence of the EHR has created efficiencies that CMS is only now trying to tap into.

Wait: More proposals on the docket

CMS’ documentation proposals don’t stop there. The agency also seeks to allow physicians to confirm changes within the history and exam elements of the current guidelines, rather than redocument a list of required elements, such as the review of a specific number of systems.

Also, for new and established patients, providers could verify, rather than re-enter, the chief complaint and patient history when those elements are captured by clinical staff. “That’s huge,” says Betsy Nicoletti, president of Medical Consulting and Reimbursement in Northampton, Mass., about how that wrinkle could streamline patient documentation.

While the proposals could drastically shake up the elements surrounding E/M encounters, CMS admits, at this point, “that many details related to program integrity and ongoing refinement would need to be developed over time.”

“The subregulatory guidance is going to be absolutely critical,” Shah says.

The changes could come, in one form or another, as soon as Jan. 1, although the agency adds that a delayed implementation of 2020, for example, would “allow the AMA time to develop changes to the CPT coding definitions and guidance prior to our implementation.” CMS says that the AMA may want to consider changes to medical decision-making or code definitions, which the agency would then consider for adoption.

A year delay “would also allow other payers time to react and potentially adjust their policies,” CMS says. — *Richard Scott* (rscott@decisionhealth.com)

More fee schedule coverage online

Part B News staff combed the 1,473 pages of the proposed 2019 Medicare physician fee schedule to bring you complete coverage of the changes that could affect your practice. Go online to www.partbnews.com to see more analysis of the rule.

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