Introduction

The Medicare PFS proposals for calendar year (CY) 2019 include information on what we might find in the Federal Register at the end of this year for CY 2019. It is important to remember that CMS will review all comments before issuing a final fee schedule rule later in the fall of 2018. So, this article is presented to just inform you of some of the changes that might be occurring next year.

You will be shown how to comment on your own at the bottom of this article.

The Biggest Change is E/M Coding, Documentation and Reimbursement

CMS has included a proposal designed to change evaluation and management (E/M) documentation and payment. Basically, there will be four reimbursement rates for new and established patients.

According to CMS, they propose simplifying E/M coding by blending CPT codes 99202-99205 - codes that cover new patient office visits levels two through five - into a single payment of $135. Nationally, a 99204 allowable is $167.

Similarly, CMS proposes blending established patient office visits levels two through five that currently are covered by CPT codes 99212-99215 into a single payment of $93. Nationally, a 99214 allowable is $109.

TABLE 19: Preliminary Comparison of Payment Rates for Office Visits New Patients

HCPCS Code	CY 2018 Non-facility Payment Rate	CY 2018 Non-facility Payment Rate under the proposed Methodology
99201	$45	$44
99202	$76	$135
99203	$110	
99204	$167	
99205	$211	

TABLE 20: Preliminary Comparison of Payment Rates for Office Visits Established Patients

HCPCS Code	Current Non-facility Payment Rate	Proposed Non-facility Payment Rate
99211	$22	$24
99212	$45	$93
99213	$74	
99214	$109	
99215	$148	

99211 and 99201 will still be billable and reimbursed at a different payment level. With that, the proposal includes four different payment levels instead of 10 as in year's past – proposed.

Those providers paid on an RVU basis would also be impacted by these changes, as regardless of the level of new or established patient visit coded, the employer is still only getting one allowable amount. Below is the proposed work RVU (WRVU) for the changes proposed by CMS.

Calculations

I took one of my busy IM client's productivity for the last 12 months and compared the reimbursement for 2018 vs the proposed change – these figures do not include the Complexity Add-on Codes that would increase the allowable for this provider on average of five dollars per documented event:

	2018	2018	2019		
	Allowable	Units	Allowable	2018	2019
99211	$ 22.00	63	$ 24.00	$ 1,386.00	$ 1,512.00
99212	$ 45.00	324	$ 93.00	$ 14,580.00	$ 30,132.00
99213	$ 74.00	5302	$ 93.00	$ 392,348.00	$ 493,086.00
99214	$ 109.00	271	$ 93.00	$ 29,539.00	$ 25,203.00
99215	$ 148.00	4	$ 93.00	$ 592.00	$ 372.00
				$ 438,445.00	$ 550,305.00
	2018	2018	2019		
	Allowable	Units	Allowable	2018	2019
99201	$ 45.00	1	$ 44.00	$ 45.00	$ 44.00
99202	$ 76.00	7	$ 135.00	$ 532.00	$ 945.00
99203	$ 110.00	144	$ 135.00	$ 15,840.00	$ 19,440.00
99204	$ 167.00	54	$ 135.00	$ 9,018.00	$ 7,290.00
99205	$ 211.00	4	$ 135.00	$ 844.00	$ 540.00
				$ 26,279.00	$ 28,259.00
				Total 2018	Total 2019
				$ 464,724.00	$ 578,564.00
				Increase	$ 113,840.00

CMS RVU Information for Those on WRVU Salary

> *Specifically, we are proposing a work RVU of 1.90 for CPT codes 99202-99205. Similarly, we are proposing a work RVU of 1.22 for CPT codes 99212-99215.*

So, to make up potential lost revenue for these changes to E/M coding, CMS is also proposing the development of two "G" codes that will be used in addition to an E/M code for either primary care or specialty provider related services. These codes will slightly increase the revenue generated for an outpatient initial or subsequent visit.

Visit Complexity Add-on Codes

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 evaluation and management visit).

The WRVU for this service is .07. This code has differential payment based on setting, with a payment of about $5.40 in a non-facility, office setting and $3.96 in a facility setting.

GCG0X: Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit).

This add-on code has a WRVU of .25 and a payment of about $13.70 in a facility or non-facility setting.

Prolonged Service Change

Likewise, a new "G" code for prolonged services is being considered as a way to support longer interactions with patients, but less time than the 60 minutes required for the current prolonged service codes for outpatient services.

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 Evaluation and Management or psychotherapy service).

This code has a WRVU of 1.17. Payment in a non-facility would be about $67.40 and in a facility $63.80.

Brief Virtual Check-In

GVCI1: 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.
The non-facility payment would be about $15.40 and the facility payment would be $13.37.

This would only be allowed for established patients, and only providers with E/M services in their scope of practice could bill it. CMS is seeking comments about requiring verbal consent to bill and frequency limitations.

Remote Services

CMS is going to pay your provider almost $13 to look at a picture from a patient and reply to them "verbally." There is a .18 WRVU for this service, an office payment of about $12.97 and facility payment of $10.09. The code will change, but it is listed as **GRAS1**.

Overall Summary of Potential EM Changes

- Establishing single, blended payment rates for new and established patients for office/outpatient E/M level 2 through 5 visits and a series of add-on codes to reflect resources involved in furnishing primary care and non-procedural specialty generally recognized services;
- Allow practitioners to choose to document office/outpatient E/M visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines or, alternatively, practitioners could continue using the current framework;

- Expanding current options by allowing practitioners to use time as the governing factor in selecting visit level and documenting the E/M visit, regardless of whether counseling or care coordination dominate the visit;
- Expanding current options for documentation of history and exam, to allow practitioners to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information;
- Allowing practitioners to simply review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it;
- Institute a payment reduction of 50 percent, applied to the lower paid of two services, when physicians report an E/M service and a procedure on a single day;
- Develop a set of new "G" codes to consider extra clinical conditions encountered by primary care and specialty practitioners;
- Primary care G code is estimated to bring in an additional five dollars while the specialty G code is an additional 13 dollars to the E/M visit;
- Adding a new prolonged face-to-face E/M code, as well as a technical modification to the practice expense methodology;
- Virtual check-in when a provider communicates with a patient without a face-to-face encounter; and
- A potential remote services G code for viewing images and verbally responding to patient regarding findings.

Proposed Revisions to Documentation Requirements for Levels 2 through 5

CMS proposes two additional choices for documentation of E/M services in addition to the original framework of the E/M Documentation Guidelines published in 1995 and 1997:

- Medical decision-making (MDM); or
- Time.

This will allow providers in different specialties to choose to document the factors that matter most given the nature of their practice. For payment purposes, CMS would require documentation only as necessary to support the medical necessity of the visit and the documentation that is associated with a current level 2 CPT code visit.

For example, for a practitioner choosing to document using the current framework (1995 or 1997 Documentation Guidelines), would document the following in order to bill any level of E/M visit from levels 2 through 5: (1) a problem-focused history that does not include a review of systems (ROS) or a past, family or social history (PFSH); (2) a limited examination of the affected body area or organ system; and (3) straightforward MDM measured by minimal problems, data review and risk (two of these three).

CMS also allows time or duration of visit to be used as the driving factor in selecting the appropriate E/M visit level only when counseling and/or coordination of care accounts for more than 50 percent of the face-to-face physician/patient encounter (or, in the case of inpatient E/M services, the floor time). Under the Proposed Rule, practitioners would have the choice to use the time-based standard for all E/M visits. CMS proposes to require practitioners 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.

On the following pages, you'll see CMS projected financial impact by specialty:

Specialty	Allowed Charges (in millions)	Estimated Potential Impact of Valuing Levels 2-5 Together, With Additional Adjustments
OBSTETRICS/GYNECOLOGY	$664	4%
NURSE PRACTITIONER	$3,586	3%
HAND SURGERY	$202	Less than 3% estimated increase in overall payment
INTERVENTIONAL PAIN MGMT	$839	
OPTOMETRY	$1,276	
PHYSICIAN ASSISTANT	$2,253	
PSYCHIATRY	$1,260	
UROLOGY	$1,772	
ANESTHESIOLOGY	$1,995	Minimal change to overall payment
CARDIAC SURGERY	$313	
CARDIOLOGY	$6,723	
CHIROPRACTOR	$789	
COLON AND RECTAL SURGERY	$168	
CRITICAL CARE	$334	
EMERGENCY MEDICINE	$3,196	
ENDOCRINOLOGY	$482	
FAMILY PRACTICE	$6,382	
GASTROENTEROLOGY	$1,807	
GENERAL PRACTICE	$461	
GENERAL SURGERY	$2,182	
GERIATRICS	$214	
INFECTIOUS DISEASE	$663	

INTERNAL MEDICINE	$11,173	Minimal change to overall payment
INTERVENTIONAL RADIOLOGY	$362	
MULTISPECIALTY CLINIC/OTHER PHYS	$141	
NEPHROLOGY	$2,285	
NEUROSURGERY	$812	
NUCLEAR MEDICINE	$50	
OPHTHALMOLOGY	$5,542	
ORAL/MAXILLOFACIAL SURGERY	$57	
ORTHOPEDIC SURGERY	$3,815	
OTHER	$30	
PATHOLOGY	$1,151	
PEDIATRICS	$64	
PHYSICAL MEDICINE	$1,120	
PLASTIC SURGERY	$387	
RADIOLOGY	$4,898	
THORACIC SURGERY	$360	

VASCULAR SURGERY	$1,132	
ALLERGY/IMMUNOLOGY	$240	Less than 3% estimated decrease in overall payment
AUDIOLOGIST	$67	
HEMATOLOGY/ONCOLOGY	$1,813	
NEUROLOGY	$1,565	
OTOLARNGOLOGY	$1,220	
PULMONARY DISEASE	$1,767	
RADIATION ONCOLOGY AND RADIATION THERAPY CENTERS	$1,776	
RHEUMATOLOGY	$559	-3%
DERMATOLOGY	$3,525	-4%
PODIATRY	$2,022	-4%
TOTAL	$93,486	0%

QPP and MIPS

Regarding changes related to the QPP's Merit-based Incentive Payment System, CMS proposes to, among other things, require eligible clinicians to move to 2015-edition certified electronic health record technology; and retain, but revise, the low-volume threshold, so that eligible clinicians can opt in if they meet one or two, but not all, of the low-volume threshold criteria.

Additionally, CMS proposes establishing new category weighting for the 2019 performance year that would set:

- Quality at 45 percent,
- Cost at 15 percent,
- Promoting interoperability at 25 percent, and
- Improvement activities at 15 percent.

OPPS Changes in Proposed Rule

Section 603 of the Bipartisan Budget Act of 2015 (BBA) reduced the payments to off-campus provider-based hospital departments to the amount paid to physician clinics for the same service, effective January 1, 2017. The good news was the BBA exempted certain sites from these payment reductions - namely those already billing under the hospital outpatient rate as of the date of enactment of the BBA (i.e., existing sites were grandfathered) and emergency services furnished by off-campus emergency departments.

In the proposed rule, CMS wants to extend this site neutrality policy beyond what is required by the BBA. Basically, CMS is proposing to cut payments to currently grandfathered sites for certain clinic visit services, citing concerns about the existing trend where more services are shifting away from doctor offices and into hospital outpatient departments.

The proposal is not budget neutral, which is why it contributes to the net overall reduction in hospital payments that would be affected under this rule. According to the agency, about a fifth of the gross $760 million in savings from the proposal would accrue to patients in the form of reduced cost-sharing.

As hospital-employed providers are on the increase, this is a proposal that could have a negative impact on the reimbursement for services provided to patients with traditional Medicare coverage under OPPS.

What Say You?

CMS will take comments on these proposed changes up to September 10, 2018. Submissions must be submitted in one of the following three ways:

1. Submit electronic comments on this regulation to http://www.regulations.gov. Follow the "Submit a comment" instructions.

2. Mail written comments to the following address ONLY:

   Centers for Medicare & Medicaid Services
   Department of Health and Human Services
   Attention: CMS-1693-P
   P.O. Box 8016
   Baltimore, MD 21244-8016

   Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail, send written comments to the following address ONLY:

   Centers for Medicare & Medicaid Services
   Department of Health and Human Services
   Attention: CMS-1693-P
   Mail Stop C4-26-05
   7500 Security Boulevard
   Baltimore, MD 21244-1850

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