**CMS Final Rule Overview**

On November 1, 2018, the Centers for Medicare & Medicaid Services (CMS) issued a final rule that includes updates to payment policies, payment rates, and quality reporting for services furnished to Medicare Part B participants on/after January 1, 2019.

I’ll outline some of the things that I feel pertain to my clients.

**Conversion Factor and Other Miscellaneous Changes**

1. The 2019 MPFS conversion factor is increasing from $35.9996 (in 2018) to $36.0391 (in 2019).
2. CMS will not apply the multiple procedure payment reduction policy to office visits and other services done on the same visit – like an E/M with biopsy, for example.
3. CMS is continuing to help small practices navigate the Quality Payment Program (QPP) in 2019 by increasing the small practice bonus to six points but including it in the Quality performance category score instead of as a standalone bonus.

**Streamlining Evaluation and Management Documentation**

CMS is finalizing a few documentation, coding, and payment changes to reduce administrative burden and improve payment accuracy for office/outpatient evaluation and management (E/M) visits over the next few years.

For 2019 and 2020, CMS is implementing some policies to provide immediate burden reduction, while other changes to documentation, coding, and payment would be implemented in 2021.

Basically, for 2019 and 2020, CMS will continue the current coding and payment structure for E/M office/outpatient visits and practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office/outpatient visits billed to Medicare.

For 2019 and 2020, CMS is finalizing the following policies – some of which may work to your advantage:

1. Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
2. For established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so;
3. For new and established patient E/M office/outpatient visits, practitioners need not re-enter in the medical record any information about the patient’s chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

Beginning in 2021, CMS will further reduce documentation and coding burdens with the implementation of payment, coding, and other documentation changes. Payment for E/M office/outpatient visits will be simplified and payment would vary primarily based on documentation that doesn’t require separate, burdensome bullet and point counting.

Specifically, for 2021, CMS is finalizing the following policies:

1. Reduction in the payment variation for E/M office/outpatient visit levels by paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients while maintaining the payment rate for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;
2. Permitting practitioners to choose to document E/M office/outpatient level 2 through 5 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;
3. Beginning in CY 2021, for E/M office/outpatient levels 2 through 5 visits, CMS will allow for flexibility in how visit levels are documented - specifically, a choice to use the current framework, MDM, or time. For E/M office/outpatient level 2 through 4 visits, when using MDM or current 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;
4. 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 beneficiary;
5. Implementation of add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. These codes would only be reportable with E/M office/outpatient level 2 through 4 visits, and their use generally would not impose new per-visit documentation requirements. (*These add-on codes will be equally valued rather than favoring specialized care as initially proposed*);
6. Adoption of a new “extended visit” add-on code for use only with E/M office/outpatient services. This code will be used to report extended time when face-to-face time exceeds 34 minutes for an established patient or 38 minutes for a new patient whose E/M service is reported as level 2 through 4; and to report a level 5 code when face-to-face time exceeds 69 minutes for established patients or 89 minutes for new patients.

CMS believes these policies will allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is relevant and medically necessary for the beneficiary. CMS intends to engage in further discussions with the public to potentially further refine the policies for 2021.

Don’t spend too much time preparing for what CMS has planned for 2021 as CMS specifically notes that the delay to 2021 allows time for CMS to consider the recommendations of the American Medical Association CPT Editorial Panel and Relative-Value Scale Update Committee (RUC) efforts to revisit coding for office and other outpatient E/M services and come up with a revised Final Rule.

**Modernizing Medicare Physician Payment by Recognizing Communication Technology-Based Services**

CMS is also finalizing their proposals to pay separately for two newly defined physicians’ services furnished using communication technology:

1. Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012) and
2. Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010)

Practitioners can be separately paid for the brief communication technology-based service when the patient checks in with the practitioner via telephone or other telecommunications device to decide whether an office visit or other service is needed. This would increase efficiency for practitioners and convenience for beneficiaries.

Similarly, the service of remote evaluation of recorded video and/or images submitted by an established patient would allow practitioners to be separately paid for reviewing patient-transmitted photo or video information conducted via pre-recorded “store and forward” video or image technology to assess whether a visit is needed.

**MIPS and QPP**

CMS also added an additional low-volume threshold exemption to MIPS for next year. To be excluded, providers or groups need to meet at least one of the following conditions:

1. Have $90,000 or less in Medicare Part B allowed charges for covered professional services.
2. Provide care to 200 or fewer Part B-enrolled patients.
3. Provide 200 or fewer covered professional services under the PFS (***new***).

The minimum period for each performance category remains unchanged, so quality and cost stay at 12 months while improvement activities and promoting interoperability remain at a continuous 90-day period.

However, the weighting to the final score of the cost and quality categories have both changed. Cost increases from 10 percent to 15 percent of the total score, and quality drops from 50 percent to 45 percent.

Overall, some of the changes in the final rule can be beneficial to primary care physicians. However, physicians should be careful with the relaxed documentation of history and examination and be clear in their documentation of review and verification of prior documentation and/or documentation by the patient or ancillary staff. What is meant to reduce a burden could become a reduction in payment if your documentation does not indicate what history and examination were included in the work of the current visit.