Changes to Evaluation & Management Coding to Have Major Impact of Government's New Ruling

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On November 1, the Centers for Medicare & Medicaid Services (CMS) released the Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019. This highly anticipated, hefty 2,378-page federal ruling outlines key reimbursement changes for 2019 – and beyond. Overall, physicians will experience a small upward bump in reimbursement, with the conversion factor increasing from $35.99 to $36.04.

According to CMS Administrator Seema Verma's separate November 8 announcement, it is worth noting that "exceptional performance" participants in the Merit-based Incentive Payment System (MIPS) will receive an additional, maximum 1.88% boost in 2019. Although that wasn't the increase successful participants hoped for, only 5% of physicians will experience the federal program's 4% decline. The lack of failure, ironically, left little to distribute to the "winners."

The federal ruling announced a multitude of new policies, but perhaps the most wide-reaching one pertained to the significant changes to the evaluation and management (E/M) codes. CMS is using a phased-in approach, starting with documentation requirement changes; the reimbursement modification will hit in 2021.

The alteration to documentation reflects an easing of requirements: "…when relevant information is already contained in the medical record [for established patients], 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." Furthermore, CMS asserts: "…for new and established patients for [E/M office] visits, practitioners need not re-enter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary." Both of these declarations may signal an opportunity to alter or revise existing workflow related to recording key elements of the visit although CMS makes it clear that the changes are optional: "Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so. We note that this policy to simplify and reduce redundancy in documentation is optional for practitioners, and they may choose to continue the current process of entering, re-entering and bringing forward

information."

Per CMS, "For CY 2019 and 2020, we will continue the current coding and payment structure for E/M office/outpatient visits, and, therefore, practitioners should continue to use either the 1995 or 1997 versions of the E/M guidelines to document E/M office/outpatient visits billed to Medicare for 2019 and 2020 (with the exception of our final policy to eliminate redundant data recording)."

As of 2021, CMS is allowing physicians to choose the level of the E/M service based solely on time regardless of the time involved in counseling and/or coordination of care, although it is important to note that the agency's emphasis is that there is a requirement to document that the visit was "medically reasonable and necessary."

For CY 2021, the codes 99212 through 99214 and 99202 through 99204 will be collapsed into single rates for established and new patients, respectively. CMS is also creating new add-on codes – GPC1X and GCG0X, respectively - for the "additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care." In addition, practitioners will be able to signal an "extended visit" with a new add-on code to be used for additional resources. The new payment rates – set to go into effect in 2021 – are highlighted in this table.

Finally, CMS is eliminating the requirement for a home visit to be substantiated by "remov[ing] the requirement that the medical record must document the medical necessity of furnishing the visit in the home rather than in the office."

Although the E/M changes represent a significant departure from current practice, the new payment for virtual care is truly groundbreaking. Administrator Verma declared when the ruling was released, "(F)or the first time in 2019, Medicare will pay doctors for virtual check ins with their patients, virtual consultations between physicians, evaluation of remote pre-recorded images and video…". CMS specifically stated that these visits are not telemedicine encounters so that they are not subject to the geographic and other restrictions on telehealth services.

As of January 1, 2019, CMS offers two new payable codes:

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, e.g. virtual check-in.

G2010: Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with 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 notes: “We are finalizing that the follow-up with the patient could take place via phone call, audio/video communication, secure text messaging, email, or patient portal communication.”

Furthermore, CMS asserts: "remote evaluation of recorded video and/or images submitted by an established patient...allow[s] practitioners to be separately paid..."

Verbal consent should be noted in the medical record for each billed “virtual visit,” although CMS expressly points out that electronic consent can be gathered for the G2010 service. There is no frequency limitation, although CMS declares its intention to analyze utilization in the coming year. CMS is not requiring any service-specific documentation requirements for this service, but it must be “medically reasonable and necessary” in order to be paid by Medicare. The payment rate is ~$14 for either service, and the services are subject to beneficiary cost sharing, which means that you must bill the patient for their portion of the financial responsibility, typically the co-insurance.

CPT codes 99451, 99452, 99446, 99447, 99448, and 99449 describing Interprofessional Consultations were formulated years ago, but they never had payment status. CMS’ stance changes in 2019, allowing payment for consultation between “practitioners that can bill Medicare independently for E/M services.” Like the other codes cited herein, Medicare requires the patient’s verbal consent to be noted in the medical record, as beneficiary cost-sharing applies.

In addition to these new codes and payment policies, CMS added two CPT codes for prolonged preventive services to the list of payable telehealth services, a modifier to distinguish telestroke services, "virtual communication" codes for community health centers, and telehealth-based home dialysis monthly ESRD-related clinical assessments.

Furthermore, CMS adds new payable services related to the opioid crisis. Instituting a provision from the Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT), CMS will include the patient’s home as a “permissible originating site for telehealth services furnished for purposes of treatment of a substance use disorder or a co-occurring mental health disorder” after July 1, 2019.

Payment amounts for drugs under Part B will be reduced, although the impact will be limited as the policy only applies to *new* drugs and only to the time period when an ASP (average sales price)based payment limit is not available: “WAC [wholesale acquisition cost]-based payments for new Part B drugs will utilize a 3 percent add-on in place of the 6 percent add-on that is currently being used.”

Welcome news to physicians involved in imaging, CMS has reduced the restrictions on supervision of registered radiologist assistants (RRA) and radiology practitioner assistants (RPA), replacing the “personal” supervision to that of a direct level of supervision as permitted by state law, and state scope of practice regulations.

CMS officially discontinues the functional reporting requirements for outpatient therapy services furnished on or after January 1, 2019, although they can still be reported in the coming year if the practice so chooses. For physical and occupational therapy, there are two new payment modifiers – CQ and CO – to identify services furnished by assistants.

Therapists are among the practitioners now considered eligible for participation in the Merit-based Incentive Payment System (MIPS); the list of participating providers is expanded to include: physical therapists, occupational therapists, qualified speech-language pathologists, qualified audiologists, clinical psychologists, and registered dietitians or nutrition professionals. Notably, these new, eligible practitioners will automatically be assigned a zero percent weighting for the Promoting Interoperability category of MIPS.

The minimum threshold for MIPS participation in 2019 is 30 points, and exceptional performance was raised to 75.

In addition to the fact that participants must use 2015 Edition certified EHR technology in 2019, the government made changes to each of the MIPS reporting categories:

- Adding 8 new quality measures, and removing 26; offering a small-practice bonus score.
- Increasing the cost category to 15% of the total MIPS score, bumping quality down to 45%; adding payment-standardized, risk-adjusted episode-based measures for cost analysis.
- Adding 6 new improvement activities, modifying 5 and removing 1.
- Changing the old “meaningful use” (and, subsequently, advancing care information) category to “promoting interoperability,” with four all-or-nothing categories: (1) eRx; (2) health information exchange; (3) provider-to-patient exchange; and (4) public health and clinical data exchange. Exclusions are available for small practices (15 eligible clinicians or less), as well as certain categories based on this broad exclusion: “Any MIPS eligible clinician who is unable to implement the measure for a MIPS performance period in 2019 would be excluded from this measure.”

Attestations can be submitted via “direct, login and upload,” or “login and attest,” replacing the EHR and registry submission terminology for reporting. CMS finalized a policy to allow clinicians, who otherwise would have been excluded under the low-volume threshold, the option to participate in MIPS. Once a physician chooses to opt in, however, the decision is irrevocable for the participation year, and he or she is subject to the penalty. As it relates to exclusions, CMS clarified that the minimum volumes of patients – 200 patients – and allowed charges - $90,000 – were based on *covered* professional services. Finally, the

200 was also applied to professional services so that the exclusion also applied if not more than 200 services were rendered.

CMS' November ruling follows on the heels of the American Medical Association's (AMA) issuance of the 2019 CPT Codes in September. There are a total of 335 changes - 212 codes added, 73 deleted and 50 revised - heading into the new year, to include three new remote physiologic monitoring codes (99453, 99454, and 99457), as well as two new interprofessional internet consultation codes (99451 and 99452), all five of which CMS agreed to cover as a paid service. In addition to these codes, the AMA announced new and revised codes for skin biopsy, fine needle aspiration biopsy, adaptive behavior analysis, and central nervous system assessments including psychological and neuropsychological testing.

2019 will most certainly be another exciting year in practice management, with novel challenges, but also new opportunities.
