Government Releases Medicare Proposed Rule for 2019

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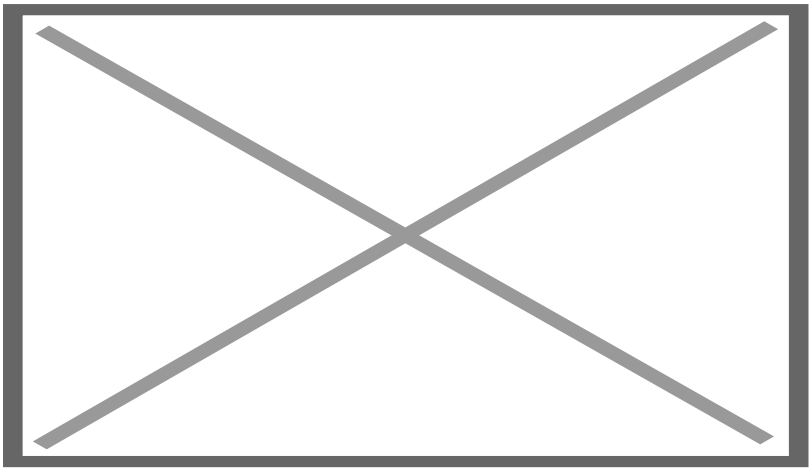
Choosing the appropriate level of an evaluation and management (E/M) codes is a daily occurrence for providers, but it's no easy task. The "correct" code for an E/M is dictated by two guiding principles – the 1995 and the 1997 Documentation Guidelines; providers must select one or the other. Both have spawned a multitude of reference tables, grids, and other "cheat" sheets to confirm that the elements of the encounter are performed in compliance with the guidelines.

In 2017, the Centers for Medicare and Medicaid Services (CMS) announced that they would launch a study of the challenges related to E/M documentation; the results were released last month in the CY 2019 Physician Fee Schedule Proposed Rule.

Declaring that the existing 10 codes for new and established patient visits are "outdated," CMS proposed a single, blended rate for 99202 through 99205 and another one for 99212 through 99215. The collapsed established patient code would be reimbursed at the national rate of $93, while the new patient rate would be $135. While the concept is arguably a good one, the proposed rates may give providers pause. (See table below).



In addition to the proposed rates, CMS recommends a softening of requirements related to key elements of the code to include the fact that providers would not be obliged to re-

record the history and physical, or the chief complaint. Instead, the provider could document that he or she reviewed, updated and verified the information, thus changing the focus on documenting that which has changed.

Providers are permitted to continue to use the 1995 or 1997 guidelines, but could instead select only medical decision making or the time spent face-to-face with the patient to support the choice of the appropriate code. This is in addition to documentation that would justify the medical necessity of the visit. The framework for the new plan would be a minimum documentation standard where providers would need only to document the information to support a level two E/M visit.

In the fact sheet issued with the proposal, CMS summarizes: “Practitioners could choose to document additional information for clinical, legal, operational or other purposes, and we anticipate that for those reasons, they would continue generally to document medical record information consistent with the level of care furnished. However, we would only require documentation to support the medical necessity of the visit and associated with the current level 2 CPT visit code.”

In addition to these “blended” codes, CMS recommends:

- A multiple procedure adjustment of 50 percent to the lowest value service that is furnished on the same day as a separately identifiable E/M.
- An add-on CPT code for use with primary care office visits, offering an additional ~$5; the code proposed is GPC1X, “*visit complexity inherent to evaluation and management associated with primary medical care services*.”
- A similar add-on code with a proposed ~$9 in reimbursement for office visits performed by certain specialties; the code GCG0X could be used for “*visit complexity inherent to evaluation and management associated with Allergy/Immunology, Cardiology, Endocrinology, Hematology/Oncology, Interventional Pain Management-Centered Care, Neurology, Obstetrics/Gynecology, Otolaryngology, Rheumatology, or Urology*.”
- An add-on code applicable for a 30-minute prolonged E/M visit.
- Removal of the requirement to justify the medical necessity of a home visit in lieu of an office visit.
- Elimination of the policy that prevents payment for same-day E/M visits by multiple providers in the same specialty within a group practice.

Virtual care was also in the spotlight in CMS’ proposal, with the federal agency recommending payment to providers for “brief, non-face-to-face assessment via communication technology,” as well as “evaluation of patient-submitted photos or recorded video.” CMS elaborates that the photos or recorded video can be “conducted via pre-recorded ‘store and forward’ video or image technology to assess whether a visit is needed.” The proposed CPT codes are GVCI1 and GRAS1, respectively. CMS is also recommending separate payment for “Chronic Care Remote Physiologic Monitoring” and

"Interprofessional Internet Consultation."

For more information on the E/M and virtual care proposal, CMS provides a quick reference guide to these changes.

Although E/M documentation changes and virtual care were in the spotlight, the CY 2019 Physician Fee Schedule Proposed Rule incorporated many other recommendations, to include:

- Reducing the quality measure set for the Medicare Shared Savings Program's Accountable Care Organizations from 31 to 24;
- Dropping the drug payment add-on to three percent for wholesale acquisition costs (WAC)-based payments for new Part B drugs, instead of the current six percent;
- Eliminating the functional status reporting requirements for outpatient therapy; and
- Softening the requirement related to the "personal supervision" requirement for radiology technicians.

Not surprisingly, CMS is also proposing more changes to the Quality Payment Program, declaring a need to overhaul the "promoting interoperability" criteria. (This is CMS' new name for the "meaningful use" standards, which was subsequently named "advancing care information"; these have been replaced by the term "promoting interoperability.")

At present, these proposals are simply on the table for consideration. CMS will release the "final" word for 2019 in early November. Once the government's finalized plan is in place, we will report on it in The Sentinel.

For a full text of the 665-page proposed rule, click here.
