CMS Proposes E/M Visit Documentation and Requirement Changes

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CMS has proposed a major new rule seeking to streamline the documentation required by practitioners for evaluation and management ("E/M") visits while simultaneously reconfiguring the corresponding payment scheme for E/M visits. While many in the industry are welcoming the efforts by CMS to remedy the burdensome and convoluted documentation requirements that have become the norm for E/M visits, many are also greatly concerned about the changes being proposed to the reimbursement of Level 4 and Level 5 visits that are predicted to result in lower overall reimbursement for several specialties. CMS' Notice of Proposed Rulemaking titled "Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019" was published in the Federal Register on July 27, 2018 with a proposed effective date of January 1, 2019 if the rule is adopted.[1] The proposed rule focuses on E/M visits in the office/outpatient setting and thus the corresponding five levels of E/M visit codes.[2] Potential amendments to the inpatient setting are being contemplated by CMS for future proposed rules.

I. E/M Visit Background

Practitioners providing common office visits for E/M services bill under a relatively generic set of CPT codes that distinguish visits based on level of complexity, site of service, and whether the patient is new or established. The three key components to the CPT codes include the (1) history of present illness; (2) physical examination; and (3) medical decision making ("MDM"). In its most basic sense, with each increasing E/M level both the complexity and payment increases.

For coding and billing E/M visits to Medicare for a patient encounter, practitioners have historically utilized one of two versions of the E/M Documentation Guidelines from 1995 and 1997.[3] Practitioners have relied upon these guidelines to specify the medical record information within each of the above three key components that are needed to support billing for a given level of E/M visit. Additionally, according to both Medicare claims processing manual instructions and CPT coding rules, when counseling and/or coordination of care accounts for more than 50% of the face-to-face physician/patient encounter, the duration of the visit can be used as an alternative basis to select the appropriate E/M visit level.[4] In fact, both the 1995 and 1997 E/M guidelines address time and recognize that where counseling and/or coordination of care dominates the physician/patient encounter, then time is considered the key or controlling factor to qualify for a particular level of E/M services.[5]

CMS' proposed rule seeks to expand the documentation options available to practitioners to meet Medicare requirements.

II. Proposed Revisions to the E/M Documentation Requirements

CMS notes in its proposed rule that "[s]takeholders have long maintained that all of the E/M documentation guidelines are administratively burdensome and outdated with respect to the practice of medicine."[6] Consequently, after reviewing the system over the past several years and soliciting comments and feedback from the industry, CMS now acknowledges these shortcomings and has proposed this new rule. It is important to note that CMS' effort to streamline and lessen the documentation burdens is tied to the proposed revisions to the payment structure for E/M visits (as discussed below). Thus, arguably any effort by practitioners to push back on the revised payment structure would almost certainly result in CMS simultaneously walking back the proposed revised documentation requirements. However, it seems likely that changes are going to occur to both aspects of E/M visits and therefore the question now is how and when rather than if.

In an effort to simplify documentation, CMS proposes "to allow practitioners to choose, as an alternative to the current framework specified under the 1995 or 1997 guidelines, either MDM or time, as a basis to determine the appropriate level of E/M visit."[7] The goal is to provide flexibility so that

different practitioners in different specialties will be able to choose to document the factor(s) that matter the most given the nature of their particular clinical practice. CMS believes this will help alleviate the need of practitioners to document, as a matter of course, extensive histories of present illness, physical examinations and MDM data in the medical records for each and every patient. CMS claims that the purpose is to provide choice and as such, practitioners would be permitted to use MDM, time or to continue utilizing the current 1995 or 1997 guideline framework for documentation. Importantly, however, continuing to utilize the historic 1995 or 1997 guidelines would not allow practitioners to avoid the proposed revised reimbursement structure discussed below.[8]

For purposes of payment, CMS would only require documentation by practitioners to support medical necessity and to satisfy the documentation requirements currently associated with a Level 2 visit for history, exam and/or MDM. With that said, practitioners could choose to document more for clinical, legal, operational or other purposes. By way of example, for a practitioner choosing to document utilizing the current 1995 or 1997 guidelines, the proposed minimum documentation for a Level 2 through Level 5 would include: "(1) a problem-focused history that does not include a review of systems or a past, family, or social history; (2) a limited examination of the affected body area or organ system; and (3) straightforward medical decision making measured by minimal problems, data review, and risk (two of these three)."[9]

Alternatively, if the practitioner was choosing to document based on MDM alone, "Medicare would only require documentation supporting straightforward medical decision-making measured by minimal problems, data review, and risk (two of these three)."[10]

Finally, CMS is proposing to allow practitioners to have the choice to use the time-based standard for E/M visits by documenting medical necessity of the visit and then showing the total amount of time spent face-to-face with the patient regardless of the amount of counseling and/or care coordination furnished as part of the patient encounter. Currently CMS has proposed typical times of 31 minutes for established patients and 38 minutes for a new patient to justify payment for E/M visit Levels 2 through 5. While CMS noted in its proposed rule that some have raised concerns about possible abuse and inequities in allowing this method, CMS is nevertheless proposing it and requesting additional comments on how best to implement time requirements for reimbursement.[11]

Additionally, CMS proposes to simplify documentation with the following additional changes:

- CMS proposes eliminating the need to document medical necessity for a visit to occur in the home versus in an office or outpatient setting, leaving it to the practitioner to determine where best to provide care for the patient.[12]
- For established patient visits, CMS proposes eliminating the need of practitioners to supplement or confirm a review of systems or pertinent past, family, and/or social history, instead requiring the practitioner to only document on what has changed since the last visit.[13]
- For both new and established patient visits, CMS proposes eliminating the requirement that practitioners re-enter information in the medical record regarding the chief complaint and history that are already entered by ancillary staff or the beneficiary.[14]

CMS believes that these changes will eliminate significant amounts of administrative time documenting that are wasted by practitioners.

III. CMS' Proposed Revision to the E/M Payment Rates

In conjunction with the changed requirements for documentation, CMS proposes to "simplify" payments for E/M visits in the office/outpatient setting by eliminating several of the payment categories and paying one single rate for Level 2 through Level 5 E/M visits. These revisions would apply to both new and established patients. Practitioners would still bill the particular CPT code for the particular level of E/M service provided but, under the proposed rule, would be paid at the single rate for anything coded at a Level 2 through Level 5. To allow practitioners to "better capture the differential resources involved in furnishing certain types of E/M visits," CMS proposes creating new add-on codes.[15] The proposed new rates would be as follows:

New Patient	**2018 Rate, National Avg**	**2019 Rate, Proposed, National Avg**
99201	$45	$44
99202	$76	$135
99203	$110	$135
99204	$167	$135
99205	$211	$135
Established Patient	**2018 Rate, National Avg**	**2019 Rate, Proposed, National Avg**
99211	$22	$24
99212	$45	$93
99213	$74	$93
99214	$109	$93
99215	$148	$93

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Without taking into account the add-on codes (discussed below) the revised rates provide greater reimbursement for practitioners that historically billed services at a Level 2 or Level 3 while decreasing the reimbursement of practitioners that historically billed services at a Level 4 or Level 5. Thus, on its face, many specialists would face cuts in their total reimbursement.

According to CMS, the motivation behind these changes in rates is to eliminate the need to audit against the visit levels and thereby alleviate from the burdens of documentation. Moreover, CMS believes that the change will "eliminate the increasingly outdated distinction between the kinds of visits that are reflected in the current CPT code levels in both the coding and the associated documentation rules."[16] Thus, CMS believes that these new rates more accurately represent the valuation of a typical E/M service.

To offset the decrease in reimbursement, CMS proposes add-on codes that will result in additional add-on payments for certain types of visits where there are higher corresponding resource costs warranting reimbursement. The three particular types of visits identified by CMS where these add-ons would be appropriate include: (1) separately identifiable E/M visits furnished in conjunction with a 0-day global procedure; (2) primary care E/M visits for continuous patient care; and (3) certain types of specialist E/M visits, including those with inherent visit complexity.[17] Thus, CMS proposes a number of adjustments to better capture the variety of resource costs that occur with these varying types of E/M visits.[18]

- To account for resource overlap between stand-alone visits and global periods, and to recognize efficiencies, particularly when there are E/M visits on the same day as procedures, CMS proposes reducing the least expensive procedure or visit by 50% when both are furnished by the same practitioner on the same day.
- To more accurately account for the face-to-face portion of primary care services with established patients, CMS proposes creating a new HCPCS add-on G-code (GPC1X) that can be billed in addition to the E/M code to account for the additional resources frequently required for additional communication, education, and consideration of the patient's medical needs. CMS also notes that this add-on code can be used to account for other face-to-face care management, counseling, or treatment of acute or chronic conditions not accounted for by other coding.
- CMS proposes creating a second new HCPCS add-on G-code (GCG0X) to account for the additional resources expended by specialties including endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, and interventional pain management-centered care. CMS acknowledges that these specialties generally provide predominantly non-procedural approaches to complex conditions that are intrinsically diffuse to multi-organ or neurologic conditions as reflected by the large proportion of Level 4 and Level 5 E/M visits reported by these specialties. Thus, additional resources are expended and additional reimbursement is warranted.
- To help maintain payment accuracy and account for the determining factor of time for an E/M visit, CMS proposes creating a new HCPCS add-on G-code (GPR01), which would be utilized for E/M psychotherapy services that require more than the customary 30 minutes for a visit.

CMS' proposed rule also includes several other proposed revisions including new codes for podiatry services to reflect their lower resource cost and adjustments to the practice expense (PE)/human resource (HR) value calculation.[19] These changes and others are discussed in greater detail in the proposed rule.

Despite CMS' claimed efforts to simplify documentation and to streamline the reimbursement process for the better of all practitioners, its own proposed rule acknowledges that there are going to be winners and losers resulting from the changes discussed in the proposed rule. Regardless of the fact that these various add-ons are created to offset the decreased rates and account for additional resource utilization, the ultimate reimbursement if this rule is adopted will change for almost all practitioners. The accompanying chart is an estimate published by CMS of the impacts of this entire new proposed rule on the various specialties.[20]

Consequently, while obstetricians/gynecologists, hand surgeons, nurse practitioners, physician assistants and urologists may very well see an increase of a few percentage points of reimbursement for their Level 2 through Level 5 services, many other specialties including dermatology, rheumatology, oncology, neurology and hematology are likely to see several percentage point decreases in reimbursement for their Level 2 through Level 5 services.

IV. Conclusion

While CMS admits in its proposed rule that it is still trying to determine how best to revamp and hopefully improve the documentation and reimbursement scheme for E/M visits, it is clear that change is coming in some form. How quickly that change occurs is also up for debate as CMS has also asked for feedback on whether to delay implementation of this proposed rule to January 1, 2020 rather than the currently planned January 1, 2019 date. Practitioners should be prepared though

Specialty	Allowed Charges (in Millions)	Estimated Potential Impact of Valuing Levels 2-5 together, without additional adjustments
Obstetrics/Gynecology	664	4%
Nurse Practitioner	3,586	3%
Hand Surgery	202	Less than 3% estimated increase in overall payment
Interventional Pain Mgt	839	
Optometry	1,276	
Physician Assistant	2,254	
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	
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
Audiology	67	
Hematology/Oncology	1813	
Neurology	1,565	
Otolaryngology	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%

for significant changes in the way they do business and CMS' comments signal this may only be the beginning as the inpatient setting may be the next to be changed.

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Footnotes

[1]83 Fed. Reg. 35704

[2]Id. at 35832

[3]https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEd\WebGuide/Downloads/95Docguidelines.pdf; https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/ MLNEdWebGuide/Downloads/97Docguidelines.pdf; and the Evaluation and Management Services guide at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf)

[4]https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/clm104c12.pdf

[5]Page 16 of the 1995 E/M guidelines and page 48 of the 1997 E/M guidelines

[6]83 Fed. Reg. 35704, 35834

[7]Id. at 35835-35836

[8]Id. at 35836

[9]Id.

[10]Id.

[11]Id. at 35836-35837

[12]Id. at 35835

[13]Id. at 35838

[14]Id.

[15] Id. at 35839

[16]Id. at 35839-35840

[17]Id. at 35840

[18]Id. at 35840-35844

[19]Id. at 35843-35844

[20]Id. at 35845-35846