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CMS PROPOSES TO SIMPLIFY CODING AND DOCUMENTATION REQUIREMENTS FOR E/M SERVICES BUT WITH A CATCH

On July 12, 2018, the Centers for Medicare & Medicaid Services (“CMS”) released its proposed rule for the Calendar Year (“CY”) 2019 Medicare Physician Fee Schedule (“Proposed Rule”). Among many other changes, CMS proposed numerous modifications to the required documentation for evaluation and management ("E/M") visits in order to alleviate the administrative burden on practitioners and to afford practitioners greater flexibility to exercise clinical judgment and discretion in what they document. However, CMS also proposed changes to payment for E/M services by proposing a single blended payment rate for all but level 1 visits.

BACKGROUND

Currently, most physicians and other billing practitioners bill E/M patient visits under a generic set of codes ("E/M visit codes") that distinguish level of complexity, site of care and, often times, between new or established patients. The CPT codes have three key components:

- History of Present Illness ("History");
- Physical Examination ("Exam"); and
- Medical Decision-Making ("MDM").

Current Medicare Physician Fee Schedule ("MPFS") payment rates for E/M visit codes increase with the level of visit billed. In order to receive Medicare payment for an E/M visit, practitioners must follow the CMS documentation guidelines for the appropriate information that must be noted in the patient's medical record to support the appropriate level of E/M visit code billed. The two versions of the CMS documentation guidelines, commonly referenced based on the year of their release (the 1995 and 1997 guidelines), are often scrutinized for being administratively burdensome and outdated. Practitioners often argue the guidelines are too complex and ambiguous, fail to distinguish meaningful differences among code levels and are not updated for changes in technology, especially electronic health record ("EHR") use. Having considered stakeholder feedback, CMS has proposed several changes to the E/M visit codes, as further detailed below. As a threshold matter, the proposed changes would only apply to office/outpatient visit codes (CPT 99201-99215 or level 1 through 5 visits). CMS stated that it would consider changes to E/M codes used in other settings such as inpatient hospital or emergency department care in future years.

PROPOSED CHANGES TO E/M VISIT CODES

First, CMS proposed to permit practitioners to choose to document office/outpatient E/M visits using MDM or time as the governing factor in selecting visit level and documenting the E/M visit. For practitioners choosing to support their coding and payment based on the amount of time spent with the patient, CMS proposed that the practitioner document the medical necessity of the visit to show the total amount of time spent by the billing practitioner face-to-face with the patient. Practitioners would still also have the option of using the current framework under the 1995 or 1997 guidelines. CMS believes that these options would allow different practitioners in different specialties to choose to document the factor(s) that matter most given their clinical practice.

Furthermore, CMS seeks to expand current options regarding the documentation of History and Exam for established patients, allowing practitioners to focus on documentation related to what changed since the patient's last visit or on pertinent items that have not changed rather than re-documenting a defined list of required elements such as review of a specified number of systems and family/social history. Additionally, for both new and established patients, CMS proposed to permit practitioners to review and verify the chief complaint and History that are already entered in the medical record by ancillary staff or the beneficiary rather than re-entering the information themselves. The practitioner could simply indicate in the medical record that he/she reviewed and verified this information.

Finally, in conjunction with its proposal to reduce the documentation requirement for E/M visits, CMS is proposing new, 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. CMS believes the new blended payment rate will improve payment accuracy and simplify the documentation process. CMS states it believes its proposals will allow

practitioners more flexibility to exercise clinical judgment in documentation so focus is placed on what is clinically relevant and medically necessary for the beneficiary.

Note that CMS proposed to maintain the current CPT coding structure for E/M visits. Practitioners would still report on the professional claim the level of visit (1 through 5) they believe they furnished using CPT codes 99201-99215. It would not be material to Medicare's payment decision which CPT code of levels 2 through 5 is reported on the claim, except to justify billing a level 2 or higher visit in comparison to a level 1 (assuming the visit is reasonable and necessary). Even though there would be no payment differential for level 2 through 5 E/M visits, CMS still believes that documentation requirements need to be simplified to better align with the current practice of medicine and to eliminate unnecessary aspects of the current documentation framework.

CMS proposed that the E/M visit policies be implemented effective January 1, 2019 but is seeking comment whether a delayed implementation date such as January 1, 2020 would be appropriate. Additionally, CMS is considering updates to E/M visit coding and documentation in other care settings in future years. It is anticipated that CMS will release its Final Rule sometime in November.

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