



# Calendar Year (CY) 2019 Medicare Physician Fee Schedule (PFS) Proposed Rule

## Documentation Requirements and Payment for Evaluation and Management (E/M) Visits & Advancing Virtual Care

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# Introduction

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# Patients Over Paperwork

- The [Patients Over Paperwork](#) initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients' ability to make decisions about their own care.
- Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
- This Administration has listened and is taking action.
- The proposed changes to the Physician Fee Schedule address those problems head-on, by proposing to streamline documentation requirements to focus on patient care and proposing to modernize payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.



# Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is required for physicians and others to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient's health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient's immediate treatment and monitor the patient's health care over time.
- **Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.**



# Documenting E/M Requires Choosing the Appropriate Code

- **Currently, documentation requirements differ for each level and are based on either the 1995 or 1997 E/M documentation guidelines.**
- Billing Medicare for an Evaluation and Management (E/M) visit requires the selection of a Current Procedural Terminology (CPT) code that best represents:
  - Patient type (new v. established),
  - Setting of service (e.g. outpatient setting or inpatient setting), and
  - **Level of E/M service performed.**

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# Level of E/M Visits

- The code sets to bill for E/M services are organized into various categories and levels. In general, the more complex the visit, the higher the level of code a practitioner may bill within the appropriate category.
- The three key components when selecting the appropriate level of E/M services provided are **history, examination,** and **medical decision making.** For visits that consist predominantly of counseling and/or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M services.



# Proposed Payment for Office/Outpatient Based E/M Visits

- Proposing a single PFS payment rate for E/M visit levels 2-5 (physician and non-physician in office based/outpatient setting for new and established patients).
- Proposing a **minimum documentation** standard where, for Medicare PFS payment purposes for an office/outpatient based E/M visit, practitioners would only need to document the information to support a level 2 E/M visit (except when using time for documentation).



# Why Change?

- Stakeholders have said that the 1995 and 1997 Documentation Guidelines for E/M visits are clinically outdated, particularly history and exam, and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care. Furthermore, the guidelines may not be reflective of changes in technology, or in particular, the way that electronic medical records have changed documentation and the patient's medical record.
- According to stakeholders, some aspects of required documentation are redundant
- Additionally, current documentation requirements may not account for changes in care delivery, such as a growing emphasis on team-based care, increases in the number of recognized chronic conditions, or increased emphasis on access to behavioral health care.



# Medical Decision Making or Time

- We propose 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.
- This would allow different practitioners in different specialties to choose to document the factor(s) that matter most given the nature of their clinical practice.
- It would also reduce the impact Medicare may have on the standardized recording of history, exam and MDM data in medical records, since practitioners could choose to no longer document many aspects of an E/M visit that they currently document under the 1995 or 1997 guidelines for history, physical exam and MDM.

# Proposed Payment for Office/Outpatient Based E/M Visits

Level	Current Payment* (established patient)	Proposed Payment**
1	\$22	\$24
2	\$45	\$93
3	\$74	
4	\$109	
5	\$148	

Level	Current Payment* (new patient)	Proposed Payment**
1	\$45	\$44
2	\$76	\$135
3	\$110	
4	\$167	
5	\$211	

\* Current Payment for CY 2018

\*\*Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate



# Resource Use During a Visit

- We recognize that primary care services frequently involve substantial non-face-to-face work, and note that there is currently coding available to account for many of those resources, such as chronic care management (CCM), behavioral health integration (BHI), and prolonged non-face-to-face services.
- The currently available coding still does not adequately reflect the full range of primary care services, nor does it allow payment to fully capture the resource costs involved in furnishing a face-to-face primary care E/M visit.
- We are proposing to create a HCPCS G-code for primary care services, GPC1X (Visit complexity inherent to evaluation and management associated with primary medical care services that serve as the continuing focal point for all needed health care services (Add-on code, list separately in addition to an established patient evaluation and management visit)).



# Resource Use During a Visit

- We are also proposing to create a HCPCS G-code to be reported with an E/M service to describe the additional resource costs for specialty professionals for whom E/M visit codes make up a large percentage of their overall allowed charges and whose treatment approaches we believe are generally reported using the level 4 and level 5 E/M visit codes rather than procedural coding. Due to these factors, the proposed single payment rate for E/M levels 2 through 5 visit codes would not necessarily reflect the resource costs of those types of visits.
- Therefore, we are proposing to create a new HCPCS code GCG0X (Visit complexity inherent to evaluation and management associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, cardiology, or interventional pain management-centered care (Add-on code, list separately in addition to an evaluation and management visit)).

# Summary: How to Streamline E/M Payment and Reduce Clinician Burden



- Proposing to provide practitioners choice in documentation for office/outpatient based E/M visits for Medicare PFS payment: 1) 1995 or 1997 documentation guidelines, 2) medical decision-making or 3) time.
- Proposing to expand current policy regarding history and exam, to allow practitioners to focus their documentation on **what has changed** since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information.
- Proposing to allow practitioners to **review and verify** certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.
- Soliciting comment on how documentation guidelines for medical decision making might be changed in subsequent years.



# Proposed Additional Payment Codes

- Proposing **~\$5 add-on payment** to recognize additional resources to address inherent complexity in E/M visits associated with primary care services.
- Proposing **~\$14 add-on payment** to recognize additional resources to address inherent visit complexity in E/M visits associated with certain non-procedural based care.
- Proposing a **multiple procedure payment adjustment** that would reduce the payment when an E/M visit is furnished in combination with a procedure on the same day.
- Proposing an **~\$67 add-on payment for a 30 minute prolonged E/M visit.**



# Advancing Virtual Care

- In response to the CY 2018 PFS Proposed Rule, we received feedback from stakeholders supportive of CMS expanding access to services that support technological developments in healthcare.
- We are interested in recognizing changes in healthcare practice that incorporate innovation and technology in managing patient care.
- We are aiming to increase access for Medicare beneficiaries to physicians' services that are routinely furnished via communication technology by clearly recognizing a discrete set of services that are defined by and inherently involve the use of communication technology.



# Advancing Virtual Care

To support access to care using communication technology, we are proposing to:

- Pay clinicians for virtual check-ins – brief, non-face-to-face assessments via communication technology;
- Pay Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for communication technology-based services and remote evaluation services that are furnished by an RHC or FQHC practitioner when there is no associated billable visit;
- Pay clinicians for remote evaluation of patient-submitted photos or recorded video; and
- Expand Medicare telehealth services to include prolonged preventive services.



# For Further Information

See the Physician Fee Schedule website at:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>