



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

**Documentation and Payment for Evaluation and Management (E/M)
Visits, Advancing Virtual Care, and Quality Payment Program**

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Introduction

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- Choosing Appropriate Code and Providing Supporting Documentation
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- Documentation Changes for Office/Outpatient Visits Starting in 2019
- Documentation, Coding and Payment Changes for Office/Outpatient Visits Starting in 2021
- Advancing Virtual Care
- Quality Payment Program Update



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 Physician Fee Schedule final rule addresses those problems by streamlining documentation requirements to focus on patient care and modernizing 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 necessary 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.



Levels of E/M Visits and PFS Payment

- Physicians and other practitioners paid under the PFS bill for office/outpatient E/M visits using a 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 when selecting the appropriate code to bill are **history, examination, and medical decision making (MDM)**. For visits that consist predominantly of counseling and/or coordination of care, time (in conjunction with MDM) can be used as the key or controlling factor determining visit level.
- There are currently five levels of E/M office/outpatient visits (reported using CPT codes 99201-99215). Payment increases with each level.



Choosing the Appropriate Code and Providing Supporting Documentation

- For coding and billing the PFS, practitioners may use either the 1995 or 1997 E/M documentation guidelines. These are very similar to a parallel set of guidelines present in the CPT codebook.
- These guidelines specify medical record information within each of the three components that serves as support for billing a given visit level.



Why Change?

- Stakeholders have said that the E/M documentation guidelines, and the code set itself are clinically outdated-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.



Final Policies for E/M Visits Starting in 2019

For 2019 and beyond, CMS finalized the following optional but broadly supported documentation changes for E/M visits, that do not require changes in coding/payment.

- Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;
- For history and exam for established patient office/outpatient visits, when relevant information is already contained in the medical record, 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 if there is evidence that the practitioner reviewed the previous information and updated it as needed.



Final Policies for E/M Visits Starting in 2019 (cont.)

- Additionally, we are clarifying that for chief complaint and history for new and established patient office/outpatient visits, practitioners need not re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.



Policies for E/M Office/Outpatient Visits Starting in 2021

- Beginning in CY 2021, CMS will implement payment, coding, and additional documentation changes for E/M office/outpatient visits, specifically:
 - Single rates for levels 2 through 4 for established and new patients, maintaining the payment rates for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;
 - Add-on codes for level 2 through 4 visits that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care;



Policies for E/M Office/Outpatient Visits Starting in 2021 (cont.)

- A new “extended visit” add-on code for level 2 through 4 visits to account for the additional resources required when practitioners need to spend additional time with patients.
- For level 2 through 5 visits, choice to document using the current framework, MDM or time;
 - When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary (typical CPT time for code reported, plus any extended/prolonged time).
 - When using current framework or MDM to document, for level 2 through 4 visits CMS will only require the supporting documentation currently associated with level 2 visits.



Documenting Using Time

Code(s)	Required Time (minutes)	Estimated Payment
99212	10	\$90
99213	15	\$90
99214	25	\$90
99215	40	\$148



Documenting Using Time (cont.)

Code(s)	Required Time (minutes)	Estimated Payment
99212 extended (99212 + GPRO1)	34-69	\$157
99213 extended (99213 + GPRO1)	34-69	\$157
99214 extended (99214 + GPRO1)	34-69	\$157
99215 prolonged (99215 + 99354-5)	70+	\$281+

Estimated Payment Beginning 2021 for Office/Outpatient E/M Visits

Level	Current Payment* (established patient)	Estimated Payment beginning 2021**
1	\$22	\$24
2	\$45	\$90 (\$103 for primary care and non-procedural care)
3	\$74	
4	\$109	
5	\$148	\$148

* Current Payment for CY 2018

**Estimated Payment based on the CY2019 finalized relative value units and the CY2018 payment rate

Estimated Payment Beginning 2021 for Office/Outpatient E/M Visits (cont.)

Level	Current Payment* (new patient)	Estimated Payment beginning 2021**
1	\$45	\$44
2	\$76	\$130 (or \$143 for primary care and non-procedural care)
3	\$110	
4	\$167	
5	\$211	\$211

* Current Payment for CY 2018

**Estimated Payment based on the CY2019 finalized relative value units and the CY2018 payment rate



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 utilize 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 these 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 (cont.)

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

- Pay clinicians for virtual check-ins – brief, non-face-to-face assessments via communication technology.
- Pay clinicians for remote evaluation of patient-submitted photos or recorded video.
- Pay Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs) for these kinds of services - outside of the RHC all-inclusive rate and the FQHC Prospective Payment System rate.



Advancing Virtual Care (cont.)

- Expand Medicare telehealth services to include prolonged preventive services.
- Implement policies from the Bipartisan Budget Act of 2018 for telehealth services related to ESRD patients receiving home dialysis and beneficiaries with acute stroke, and implement SUPPORT for Patients and Communities Act policy to expand telehealth services for treatment of opioid use disorder and other substance use disorders

Quality Payment Program: Merit-based Incentive Payment System (MIPS) Year 3 (2019) Final



MIPS Eligible Clinician Types:

Year 2 (2018) Final

MIPS eligible clinicians include:

- Physicians
- Physician Assistants
- Nurse Practitioners
- Clinical Nurse Specialists
- Certified Register Nurse Anesthetists
- Groups of such clinicians



Year 3 (2019) Final

MIPS eligible clinicians include:

- Same five clinician types from Year 2 (2018)
- AND:**
- Clinical Psychologists
 - Physical Therapists
 - Occupational Therapists
 - Speech-Language Pathologists
 - Audiologists
 - Registered Dieticians or Nutrition Professionals



Low-Volume Threshold Determinations:

1. Added a third element – Number of Services – to the low-volume threshold determination criteria
 - The finalized criteria include:
 - Dollar amount - \$90,000 in covered professional services under the Physician Fee Schedule (PFS)
 - Number of beneficiaries – 200 Medicare Part B beneficiaries
 - Number of services (*New*) – 200 covered professional services under the PFS
2. Added an opt-in option for Year 3
 - If you are a MIPS eligible clinician and meet or exceed at least one, but not all, of the low-volume threshold criteria, you may opt-in to MIPS
 - If you opt-in, you'll be subject to the MIPS performance requirements, MIPS payment adjustment, etc.

QPP: MIPS Year 3 (2019) Final



Performance Category Weights:

Performance Category	Performance Category Weights		
	Year 1 (2017)	Year 2 (2018)	Year 3 (2019) – Final
 Quality	60%	50%	45%
 Cost	0%	10%	15%
 Improvement Activities	15%	15%	15%
 Promoting Interoperability	25%	25%	25%



Performance Categories – Additional High-Level Changes:

Quality: Removed certain measures as a part of the Meaningful Measures Initiative and shifted the small practice bonus (worth 6 points) from the final score calculation into this performance category

Cost: Added 8 new episode measures

Facility-based quality and cost measures: Clinicians who are hospital-based can use their hospital's performance under the Hospital Value-Based Purchasing (VBP) Program for the MIPS quality and cost performance categories

Improvement Activities: Refinements made to the Improvement Activities inventory

Promoting Interoperability: Overhauled the category to simplify, focus on interoperability, align clinician policies with hospital policies, reduce measures, and change scoring to be focused on performance

QPP: MIPS Year 3 (2019) Final



Submitting Data:

Collection type- a set of quality measures with comparable specifications and data completeness criteria, as applicable, including, but not limited to: electronic clinical quality measures (eCQMs); MIPS Clinical Quality Measures* (MIPS CQMs); Qualified Clinical Data Registry (QCDR) measures; Medicare Part B claims measures; CMS Web Interface measures; the CAHPS for MIPS survey; and administrative claims measures

Submission type- the mechanism by which a submitter type submits data to CMS, including: direct, log in and upload, log in and attest, Medicare Part B claims, and the CMS Web Interface

- The Medicare Part B claims submission type is for individual clinicians or groups in small practices only to continue providing reporting flexibility

Submitter type- the MIPS eligible clinician, group, virtual group, or third party intermediary acting on behalf of a MIPS eligible clinician, group, or virtual group, as applicable, that submits data on measures and activities under MIPS

*The term MIPS CQMs ~~would~~ replaces what was formerly referred to as “registry measures” since clinicians that don’t use a registry may submit data on these measures

QPP: MIPS Year 3 (2019) Final



Performance Threshold and Payment Adjustment:

Performance Period	Performance Threshold	Exceptional Performance Bonus	Payment Adjustment*
Year 1 (2017)	3 points	70 points	Up to +4%
Year 2 (2018)	15 points	70 points	Up to +5%
Year 3 (2019) - Final	30 points	75 points	Up to +7%

*Payment adjustment (and exceptional performer bonus) is based on comparing final score to performance threshold and additional performance threshold for exceptional performance. To ensure budget neutrality, positive MIPS payment adjustment factors are likely to be increased or decreased by an amount called a “scaling factor.” The amount of the scaling factor depends on the distribution of final scores across all MIPS eligible clinicians.

Quality Payment Program: Advanced Alternative Payment Models (APMs) Year 3 (2019) Final



General:

- Increased the Advanced APM CEHRT threshold so that an Advanced APM must require that at least **75%** of eligible clinicians in each APM Entity use CEHRT
- Extended the 8% revenue-based nominal amount standard for Advanced APMs through performance year 2024
- Streamlined the definition of a MIPS comparable measure

MIPS APMs and the APM Scoring Standard:

- Reordered the wording of the criterion to state that the APM “bases payment on quality measures and cost/utilization” to clarify that the cost/utilization part of the policy is broader than specifically requiring the use of a cost/utilization measure
- Updated the MIPS APM measure sets that apply for purposes of the APM scoring standard



All-Payer Combination Option:

- Increased flexibility for the All-Payer Combination Option and Other Payer Advanced APMs for non-Medicare payers to participate in the Quality Payment Program
 - Established a multi-year determination process where payers and eligible clinicians can provide information on the length of the agreement as part of their initial Other Payer Advanced APM submission, and have any resulting determination be effective for the duration of the agreement
 - Allowing QP determinations at the TIN level in addition to the APM Entity and individual eligible clinician levels in certain instances when all eligible clinicians who have reassigned their billing rights to the TIN are included in a single APM Entity
 - Permitting all payer types to be included in the 2019 Payer Initiated Other Payer Advanced APM determination process for the 2020 QP Performance Period
- Increased the CEHRT use criterion threshold so that in order to qualify as an Other Payer Advanced APM as of January 1, 2020, CEHRT must be used by at least 75% of eligible clinicians in the other payer arrangement
- Maintained the revenue-based nominal amount standard for Other Payer Advanced APMs at 8% through performance period 2024



For Further Information

See the Physician Fee Schedule website at:

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