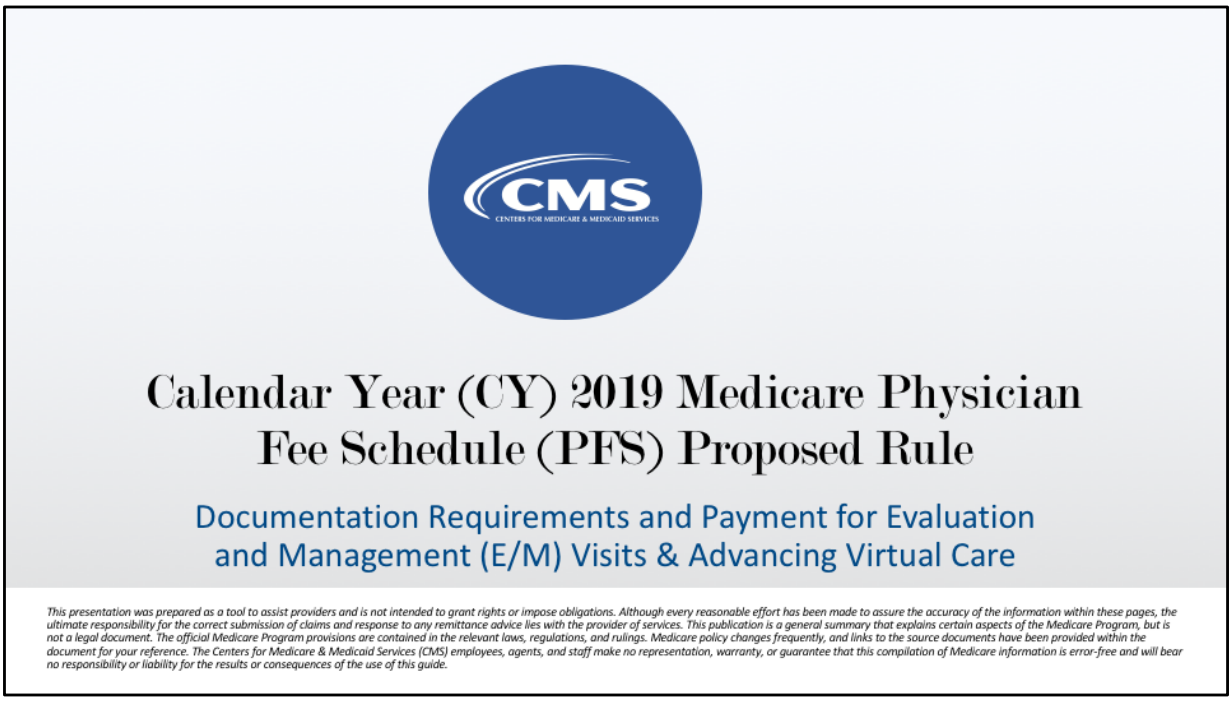

Calendar Year (CY) 2019 Medicare Physician Fee Schedule (PFS) Proposed Rule
Documentation Requirements and Payment for Evaluation and Management (E/M) Visits & Advancing Virtual Care

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Introduction

- Patients Over Paperwork
- Medical Record Documentation Supports Patient Care
- Documenting E/M Requires Choosing Appropriate Code
- Level of E/M Visits
- How to Streamline E/M Payment and Reduce Clinician Burden
- Payment for E/M – Established & New Patient
- Additional Payment Codes
- Advancing Virtual Care
- Information

2

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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.

3

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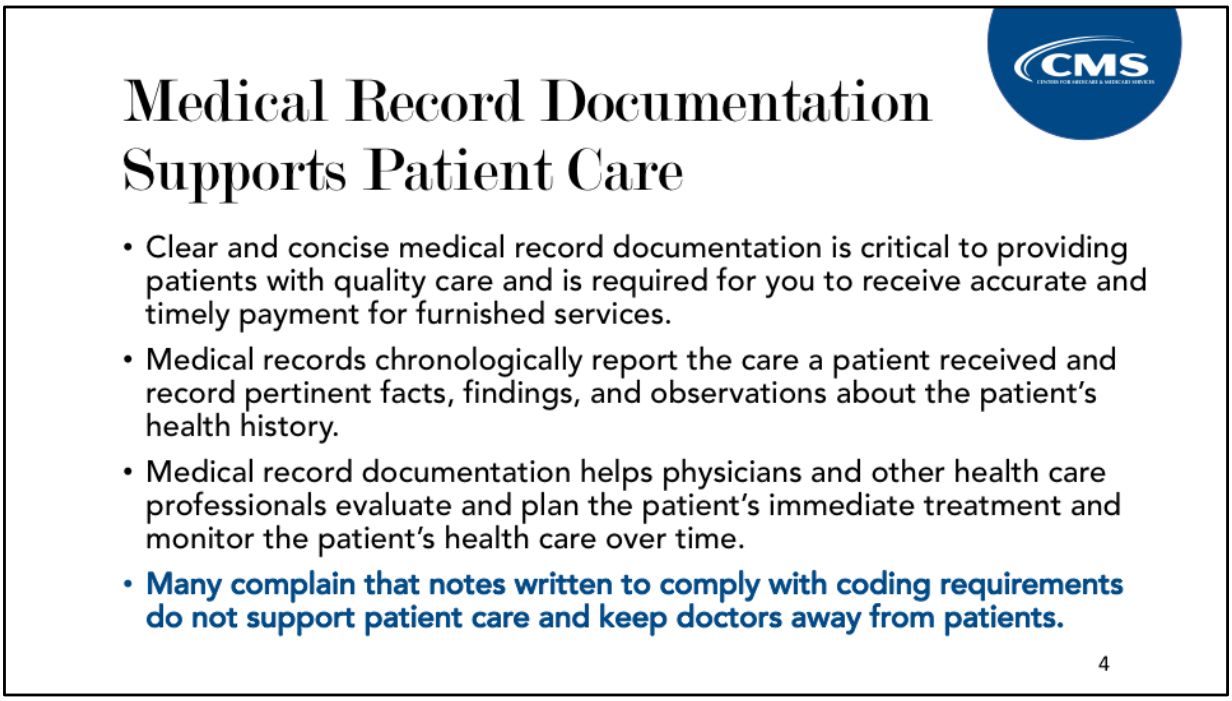
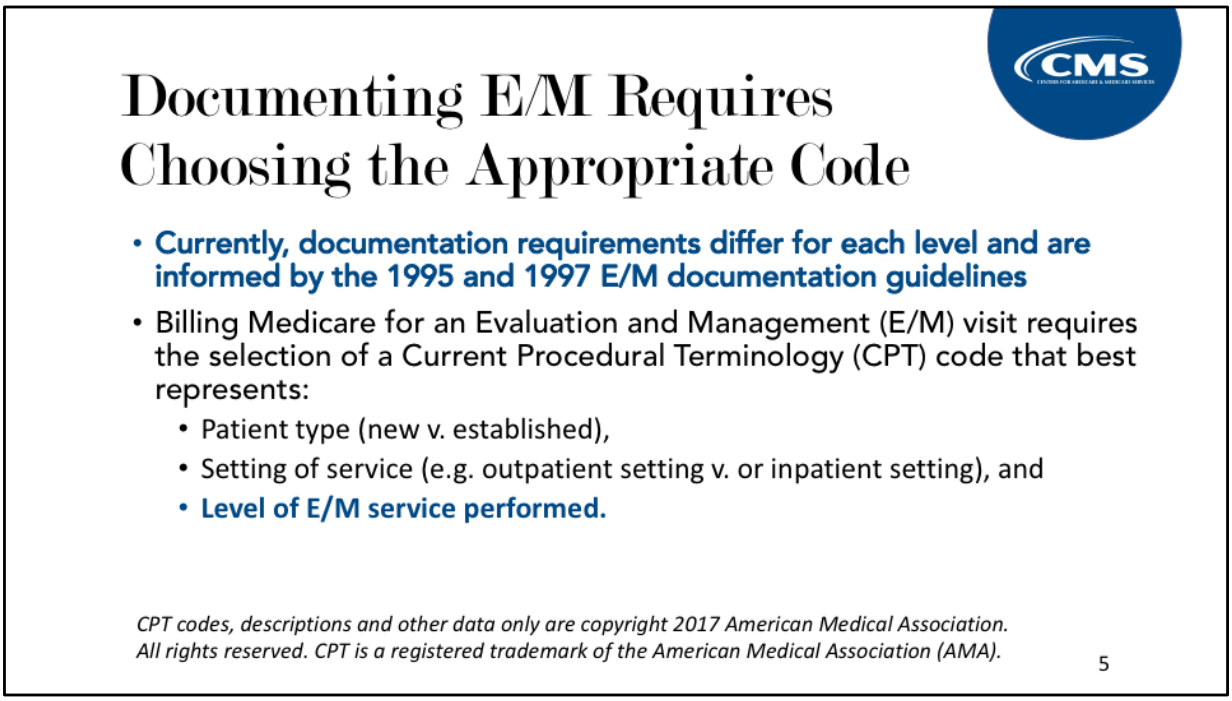


Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is required for you 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 informed by the 1995 and 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 v. 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.

6

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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.

7

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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	$172	

* Current Payment for CY 2018
**Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate

8

Proposed Payment for Office/Outpatient Based E/M Visits

Established Patient
Level 1, current payment $22*, proposed payment $24**
Level 2, current payment $45*, proposed payment $93**
Level 3, current payment $74*, proposed payment $93**
Level 4, current payment $109*, proposed payment $93**
Level 5, current payment $148*, proposed payment $93**

New Patient
Level 1, current payment $45*, proposed payment $44**
Level 2, current payment $76*, proposed payment $135**
Level 3, current payment $110*, proposed payment $135**
Level 4, current payment $167*, proposed payment $135**
Level 5, current payment $172*, proposed payment $135**

* Current Payment for CY 2018
**Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate

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, practitioners would only need to document the information to support a level 2 E/M visit.

9

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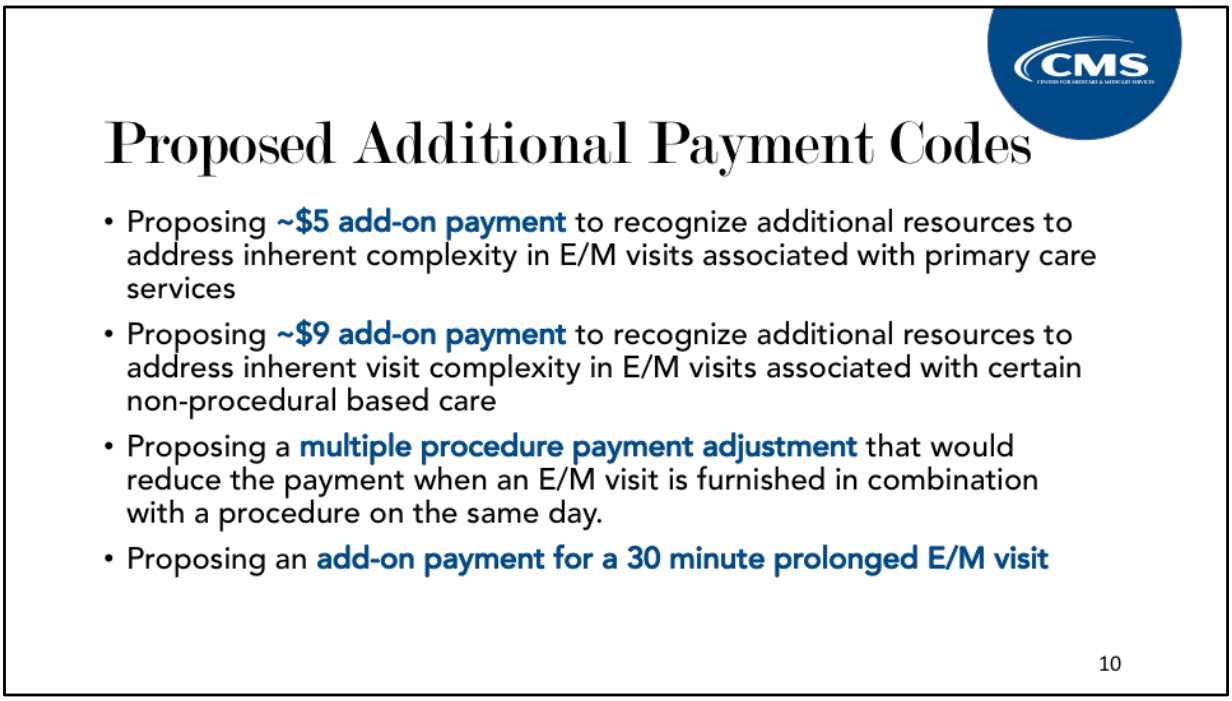

Proposed Additional Payment Codes

- Proposing **~$5 add-on payment** to recognize additional resources to address inherent complexity in E/M visits associated with primary care services
- Proposing **~$9 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 **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 incorporates 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.

11

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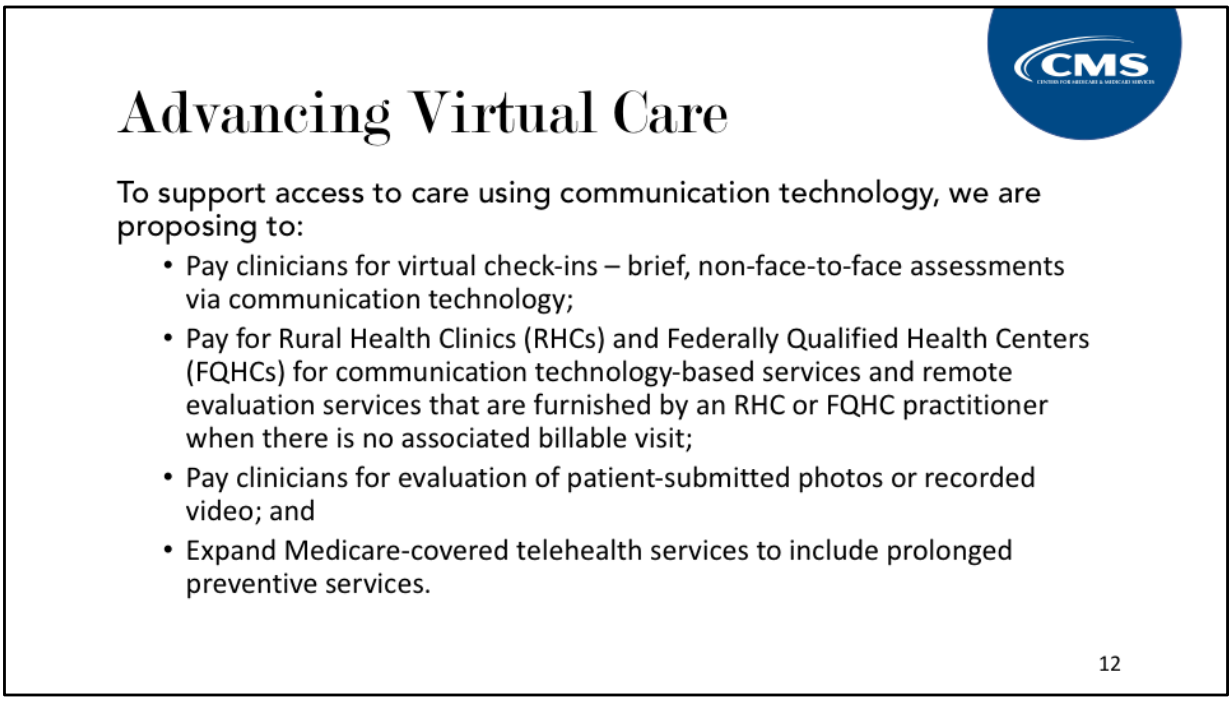

Advancing Virtual Care

- 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 for 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 evaluation of patient-submitted photos or recorded video; and
  - Expand Medicare-covered 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

13

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