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CMS Proposed Rule Regarding E/M Visit Payments and Documentation

On July 12, 2018, CMS proposed a number of payment and documentation changes to reduce administrative burden and eliminate "misvaluation" of codes for outpatient Evaluation & Management (E/M) visits furnished under the Medicare Physician Fee Schedule (PFS). Two of the proposed changes are outlined below and will fundamentally alter how CMS pays for E/M visits and how providers document those encounters. The comment period ends September 10, 2018. The final rule will take effect January 1, 2019.

E/M VISIT REIMBURSEMENT

Current Rule	Proposed Rule
✔ Five-tiered coding structure based on visit complexity ✔ Documentation required to support each code	✔ Would pay providers same rate for all E/M visits coded Level 2 to Level 5 ✔ Proposed blended rate - $135 for new patients and $93 for established ones ✔ Includes add-on codes to capture services beyond what a standard visit might involve

STREAMLINED DOCUMENTATION AND PROVIDER CHOICE

Current Rule	Proposed Rule
✔ Require providers to document text that adds no value to patient care ✔ Providers waste valuable time "clicking through screens and copying and pasting"	✔ Offers providers more flexibility to conform their documentation to the needs of their practices ✔ Providers would be able to use one of three methods to determine appropriate level for any E/M visit: (1) the current framework under the 1995 or 1997 documentation guidelines; (2) medical decision-making; or (3) time ✔ The rule would establish a minimum documentation requirement with an interval-focused history and exam ✔ Physicians could simply verify some information entered into the record by an ancillary staff member or a beneficiary instead of re-entering that data

IMPACT OF PROPOSED REGULATIONS

- ✔ Impact will vary based on provider specialty, setting, and patient population
- ✔ May disadvantage clinicians who provide more complex care
- ✔ Majority of specialties, CMS predicts a change of less than 3%
- ✔ CMS suspects the biggest winners would be OB/GYN specialists and nurse practitioners, who could enjoy 4% and 3% gains, respectively
- ✔ According to CMS, podiatrists, dermatologists, and rheumatologists fare the worst under the model, with expected decreases in payments of 4%, 4%, and 3%
- ✔ CMS predicts the reduced administrative burden will make up for any reduction in reimbursement rates
- ✔ CMS estimates proposed changes would save an individual provider 51 hours per year, if 40% of his or her patients are Medicare beneficiaries
- ✔ CMS predicts that practices' administrative costs would decline because the new blended payment would eliminate the need to audit against codes

For more information, please contact Jennifer Fisher at (919) 861-5094 or Jennifer.Fisher@youngmoorelaw.com.

Related Links:

- ✔ Letter to Doctors from CMS Administrator Seema Verma: https://www.mywcms.org/getattachment/96a5940f-dbe2-4e1e-9340-7af9d2b7b11a/CENTERS-FOR-MEDICARE.pdf?lang=en-US
- ✔ Proposed rule text: https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf
- ✔ CMS Fact Sheet for Proposed Changes to PFS: https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-07-12-2.html