Abby Moorman, Jay Jackson | August 10, 2018

CMS Proposal Would Alter Office Visit Payments /

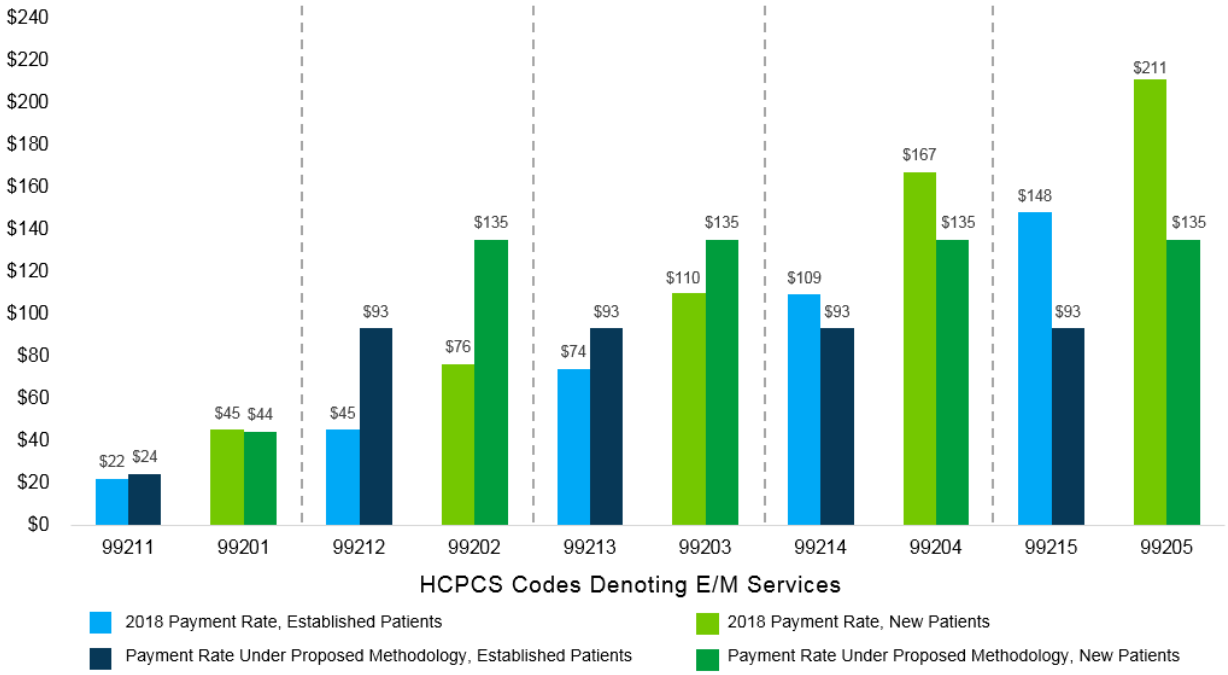
In its proposed changes to the Medicare Physician Fee Schedule (MPFS) for Calendar Year 2019 (CY2019), the Centers for Medicare & Medicaid Services (CMS) proposes a potentially sweeping change to the way it values physician office and outpatient visits, also known as Evaluation & Management (E/M) codes.

CMS proposes to alter its policies related to E/M primarily with the intention of reducing physician paperwork. CMS Administrator Seema Verma has stated the change would save 51 hours of clinic time per doctor per year.

Among the changes, CMS proposes to modify the documentation requirements for E/M visits. The agency proposes to allow providers to choose between several options to document the "level" of work conducted for the visit. CMS also proposes to lift some requirements and restrictions, such as the current requirement for documentation of medical necessity for a home visit and a restriction on billing multiple E/M codes on the same day by a single type of provider or practice.

CMS' proposed payment changes may prove to be more controversial. CMS proposes to collapse the number of payment levels within the E/M code set from 5 levels to 2. The lower level would be used by non-physician practitioners (e.g., nurse practitioners). The higher level would be used by physicians. Previously, the range of levels were available to provide higher payment for a higher level of work. CMS' proposal would also establish different payment rates for new versus established patients.

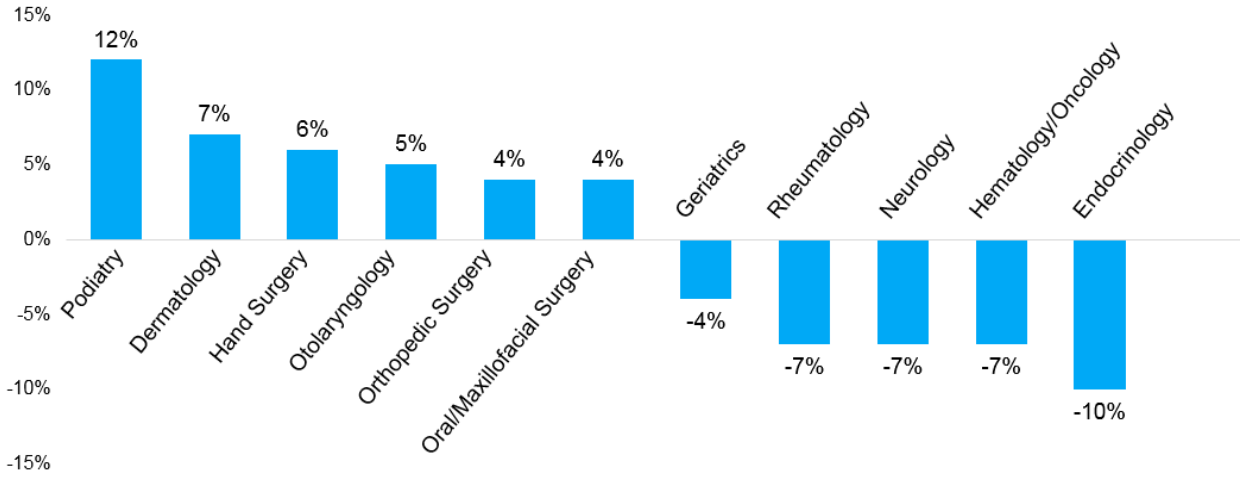
Figure 1: Current and Proposed Payment Rates for HCPCS Codes for New Patient E/M Visits



Rates shown are based on 2018 data; "proposed methodology" rates show dollar amounts as they would have been under proposed methodology in 2018, for comparative purposes. Rates for all codes are likely to change in final 2019 rulemaking under new relative value units and altered methodology

CMS estimates that the financial impact to certain specialties would be different based on the amount of time these codes are billed (Figure 2).

Figure 2: Potential Financial Impact for Select Specialties, Before Adjustment



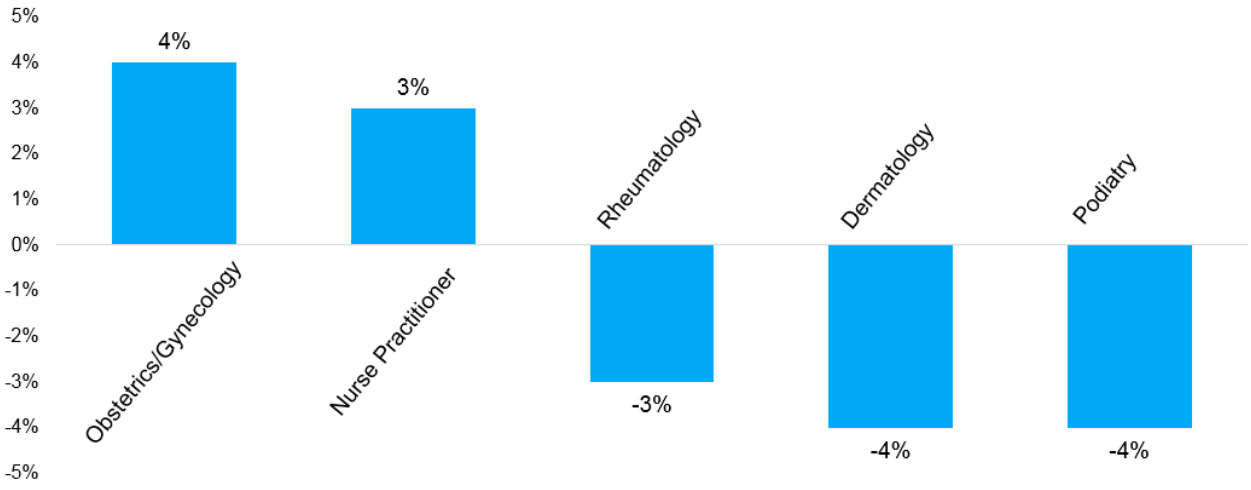
Specialties not listed are expected to be impacted at less than +/- 3%

The above estimates illustrate the direct potential impact of the E/M change proposal but do not take into account additional policies proposed by CMS.

CMS proposes to establish a series of new add-on "G" codes that would pay an additional $5.41-$67.41 per visit based on length of visit or patient complexity. It is not clear that these G codes would fully offset potential losses for certain specialties – for example, code GCG0X would pay $13.70 for a "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". This would not itself fully offset the negative payment adjustment for either a current Level 4 or Level 5 code. CMS also proposes to create a podiatry-specific G code.

These adjustments, and others such as allowed billing of multiple visits on a single day and technical updates to the fee schedule, would change the above payment dynamics and dampen "actual" anticipated impacts (Figure 3).

Figure 3: Potential Payment Impact for Select Specialties, After Adjustment



Specialties not listed are expected to be impacted at less than +/- 3%

Commercial Payment for E/M Visits

Also at issue is the impact this shift may have on non-Medicare reimbursement. CMS has proposed to operationalize its payment shift by altering the relative value units (RVU) of each code rather than the payment itself. Many commercial payers use Medicare RVUs and a different conversion factor to arrive at their payment rates. Thus, it is possible that this shift could affect all providers, regardless of patient coverage. However, the actual effect remains to be seen, and concerns have been raised that if the adjustments do not take place across the insurance industry, this change could discourage physicians from treating Medicare patients. Further, it may be difficult for providers to fulfill varying documentation requirements or to realize efficiencies if commercial insurers also do not adopt the change.

Public comment on the proposed rule closes on September 10, 2018. Changes will go into effect on January 1, 2019.

Methodology

The figures in this Insight are based on CMS data in the proposed rule, “Medicare Program; Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program” issued on July 12, 2018 and published in the Federal Register on July 27, 2018. CMS projections may change in the final rule based on updated information available to CMS and changes to the proposed policies.”

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