American Society of Anesthesiologists®

Timely Topics
PAYMENT AND PRACTICE MANAGEMENT

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Evaluation and Management: Changes Ahead

The Payment and Practice Management column in the June 2018 edition of the *ASA Monitor* alerted ASA members to watch for release of proposed rules for the CY 2019 Medicare Physician Fee Schedule (MPFS) and Year 3 (2019 Performance/2021 Payment) of the Quality Payment Program (QPP). We reminded you that, while this rule would present proposals that could undergo significant changes before CMS announces any final decision later this fall, it is important to review the rule to determine how the proposals it includes could impact the specialty overall and your practices individually. In July 2018, the Centers for Medicare & Medicaid Services (CMS) released a proposed rule that encompasses both the MPFS and the QPP. ASA members who practice pain medicine should take special interest in a very significant proposal included in the rule concerning Evaluation and Management (E/M) services for new or established patients provided in the office or outpatient setting.

Documentation

At present, determination of a level of E/M is based on the performance and documentation of care defined by a set of guidelines centered on varying levels of history, examination and medical decision making (MDM). There are two versions of the guidelines, one established in 1995 and another in 1997. Either set may be used. Most everyone in healthcare agrees that these guidelines are burdensome, overly complex and out of touch with how medicine is practiced today. The full set of 1995 and 1997 guidelines is available here and additional information on how to use them is available here.

CMS is proposing to offer choices in documentation of E/M for office and outpatient and visits.

Option 1: Level of service determined by MDM:

Under this option, the level of service would be determined by meeting criteria specific to:

- the number of diagnoses and/or management options considered, and
- the amount and/or complexity of data to be reviewed, and
- the risk of complications, morbidity and/or mortality.

CMS is proposing that this element alone could be used to support a claim for E/M services according the rules for MDM that are already in effect. However, CMS is requesting comments on how MDM could be revised going forward.

Option 2: Time:

Under the current system, the level of an E/M service is determined by three key components (history, exam, MDM) unless more than half the encounter is spent on counseling and/or coordination of care. In that case, time may be used as the determining factor. Under this proposal practitioners could use time as the single consideration in selecting a level of service– even when the encounter is not predominately counseling/care coordination. Documentation would need to support the medical necessity of the visit and the face-to-face time spent with the patient. The rule offers some options under CMS consideration for the required amounts of time.

Option 3: Current Framework:

Those who chose to do so may continue to document per the 1995 or 1997 guidelines that serve as the current standard.

Payment Rates

The proposal to reduce documentation requirements will receive a warm welcome but the next part of the proposal may be more controversial. As proposed, practitioners will still submit claims from one of five levels of service for new or established patient office or outpatient visits, but the payment rates will be collapsed into two levels. The payment amount will not be impacted by which option is used to determine and document the level of care.

	CY 2018 Payment (Non-Facility)	CY 2018 Payment (Facility)	Proposed CY 2019 Payment (Non-Facility)	Proposed CY 2019 Payment (Facility)
New Patient				
99201	$45.36	$27.36	$43.26	$25.59
99202	$76.32	$51.48	$134.45	$102.37
99203	$109.80	$78.12		
99204	$167.40	$131.76		
99205	$210.30	$172.08		
Established Patient				
99211	$21.96	$9.36	$24.15	$9.73
99212	$44.64	$25.92	$91.92	$65.60
99213	$74.16	$52.20		
99214	$109.44	$79.92		
99215	$147.60	$113.04		

Proposed CY 2019 Payment based on Relative Value Units (RVUs) per Addendum B of CY2019 Proposed Rule and Proposed Conversion Factor of $36.0463

There's More

When a physician provides an E/M service and a procedure during the same encounter, Modifier 25 *(Significant, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service)* is appended to the claim for the E/M if that E/M meets criteria eg, is not part of the pre-service work associated with the procedure. Citing concerns about duplication of resources, CMS is proposing to impose a 50% payment reduction on the least expensive service, either the visit or the procedure, performed by a physician (or a physician from the same group) on that same day of service. Given the response to a private payer's recent attempt to implement a similar policy, this is sure to generate a lot of comments!

If this reduction policy is implemented, CMS estimates savings of 6.7 million RVUs. Using the proposed CY 2019 Medicare Conversion Factor of $36.0463, that comes to *$241,510,210*. CMS will use that money to pay for new codes created to recognize that some types of visits and some patients require additional resources that may not be adequately addressed if payment is set at a single rate for E/M visits at levels 2 through 5.

New add-on codes, to be reported along with a stand-alone E/M, are to be established to recognize:

- Additional resources to address complexities in E/M visits associated with primary care services (for established patients) – GPC1X
- Additional resources to address complexities in E/M visits associated with certain non-procedural care – to include interventional pain management-centered care (for new or established patients) – GCG0X
- A prolonged service E/M with a lower time threshold than that required by CPT® code 99354 – GPR01

		Proposed CY 2019 Payment (Non-Facility)	Proposed CY 2019 Payment (Facility)
GPC1X	Visit, comp w prim med care	$5.41	$3.97
GCG0X	Visit, complex, E/M add on	$13.70	$13.70
GPR01	Prolon E/M or svs office/out	$67.41	$63.08
Proposed CY 2019 Payment based on Relative Value Units (RVUs) per Addendum B of CY2019 Proposed Rule and Proposed Conversion Factor of $36.0463			

Next Steps

CMS has offered its predictions on how each specialty may fare under this proposal. According to Table 22 within the rule, if the payment for levels 2-5 becomes a single rate and the other additional adjustments are finalized, interventional pain management would see an estimated increase of less than 3% of overall payments and anesthesiology would see a minimal change to overall payment. Other analyses that focus more precisely on the impact on payments received for E/M visits show a more pronounced effect.

Estimates may be applicable per each specialty designation, but there may be a great deal of variation on how this proposal will impact an individual practice within each specialty. As they say, your mileage may vary.

To get an idea of what this proposal may mean for your practice, you will need to run some numbers:

- How much time do you spend on documentation now? Will the decreased requirements and proposed simplification result in enough time savings that will allow you to spend more time on other activities related to patient care?
- What is your reporting pattern for the levels of service for office/patient E/M codes? As proposed, the payment for levels 2 and 3 will increase and the payment for levels 4 and 5 will decrease. Practices that report more of the latter will see more decreases than increases.
- How often do you report E/M and another service which would result in multiple procedure payment reduction (MPPR) under this proposal?
- Will the new add on codes provide sufficient revenue to offset or mitigate the change in payment rates and the MPPR?

It is important to remember that all of this is proposed; we don't know what will be in the final rule to be released in early November. CMS is sure to receive a substantial number of comments before the comment period closes on September 10, 2018.

As proposed, any new policy and payment rates would become effective January 1, 2019 but that date could change between the proposed and the final rule.

Within the rule, CMS reported that E/M services make up about 40% of allowed charges and that codes 99201-99215 represent about 20% of allowed charges under the MPFS. It follows that these codes will account for a good portion of care that a pain medicine practice provides. Take the time to review the details of the proposal. Full details are in the rule, but this CMS summary may also be of help. Then analyze how this proposal could impact your practice.