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CLIENT ALERT

CMS Proposes to Revamp Medicare Reimbursement for Evaluation and Management Services: Trading One Controversy for Another?

By Robert E. Wanerman

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Evaluation and management ("E & M") services furnished in offices or in outpatient settings account for approximately 20 percent of all Medicare Part B physician charges. Due to the volume of E & M services that are billed to Medicare Part B, the ambiguity of the E & M codes, and the fact that these codes apply to a much broader range of services than other procedure codes, E & M codes have been a source of controversy for many years as well as the basis for thousands of audits and even fraud allegations in a select number of cases.

On July 27, 2018, the Centers for Medicare & Medicaid Services ("CMS") published its proposal to revise the Medicare Part B documentation requirements for E & M services and how the Medicare program will reimburse physicians for office-based visits starting on January 1, 2019.[1] CMS explained that it is not altering either the current E & M codes or the reimbursement methodology for inpatient visits or emergency department services in this proposed rule, but left open the possibility that it might revisit these issues in the future. Comments by interested parties are due to CMS by **September 10, 2018**.

Under the current system, physicians in an office or outpatient setting bill Medicare Part B using one of five E & M codes for either new patients or existing patients (CPT codes 99201 through 99215) based on the scope and intensity of the services provided. The components of each code level are based on (1) the patient's history, (2) the physical examination of the patient, and (3) the complexity of the medical decision-making. The intensity of services ranges from Level 1 (up to five minutes, and may not require a physician's involvement) to Level 5 (approximately 40 minutes of a physician's time, and involves a comprehensive history and examination as well as a highly complex degree

[1] 83 Fed. Reg. 35704 (July 27, 2018), *available at* https://www.gpo.gov/fdsys/pkg/FR-2018-07-27/pdf/2018-14985.pdf.

of medical decision-making). These codes and their formal descriptors are controlled by the American Medical Association's ("AMA's") CPT Editorial Panel, not by CMS. Although CMS published guidelines in 1995 and 1997 for physicians explaining how to document the selection of E & M codes, those guidelines have been widely unpopular and are frequently criticized as being vague or not accurately reflecting current medical practice. These problems are most apparent when physicians are audited by Medicare Administrative Contractors, where honest differences of opinion or small defects in documentation can result in overpayment demands or allegations that the physician has engaged in fraudulent conduct.

CMS's overall goal in the proposed rule is to reduce the documentation burden on physician practices. The agency acknowledged that it cannot change the E & M codes themselves.

Proposed Changes to E & M Documentation

The proposed rule changes the process for E & M services furnished to Medicare Part B beneficiaries in an office or outpatient setting in several important ways:

- In addition to using the current documentation guidelines, CMS would allow physicians to determine the level of service based only on either (1) the time spent with a patient or (2) the level of medical decision-making, regardless of the extent of a physical exam or patient history. This expands the current rule, which allows coding based on time only when the majority of the physician's time involves counseling or coordination of care.

- The acceptable level of documentation would need to satisfy only the requirements for Level 2 (out of the five levels of possible visits), unless the physician based the claim on the time spent with the patient. The Level 2 documentation requirements can be satisfied by completing a problem-focused history, a limited examination, and routine medical decision-making. The same level of documentation would satisfy claims for any service coded as Level 2 through Level 5.

- The proposed rule would eliminate the current requirement that the physician document the medical necessity for a home visit instead of an office visit.

- The proposal to allow E & M code selection based on medical decision-making eliminates the requirement under current Medicare coding guidelines to document the patient's history and physical exam information.

- For established patients, the proposed rule would eliminate the need to document information about the patient, such as history and examination, which already is in the patient's record from prior visits. Physicians would be able to note that there has been no change in the relevant information from the earlier

review of systems and history performed on a certain date. Practitioners would only need to note any changes since the prior visit.

- For both new and established patients, the proposed rule would allow physicians to review information in the patient record entered by either ancillary staff or the beneficiary; the physician would no longer be obligated to reenter that information.

Proposed Changes to E & M Reimbursement

The proposed rule would also dramatically change how physicians are reimbursed. It would replace the current method of establishing specific reimbursement rates for each E & M code with a new system. Instead of the current progressive levels of reimbursement, CMS would establish a single reimbursement rate for each E & M code for new and established patients for all services coded as Level 2 through Level 5. CMS explained that it wants to set a single rate that aligns with the simplified documentation requirements. The impact of this proposal is illustrated in the following chart, which compares current 2018 fee schedule rates with rates if the proposed methodology is adopted:

HCPCS Code	2018 Non-Facility Payment Rate Under Physician Fee Schedule	2018 Non-Facility Payment Rate Under the Proposed Methodology
New Patients:		
99201	$45	$44
99202	76	135
99203	110	135
99204	167	135
99205	211	135
Existing Patients:		
99211	$22	$24
99212	45	93
99213	74	93
99214	109	93
99215	148	93

CMS explained that by collapsing the different payment levels into a single rate, the need to audit E & M services to determine the appropriate level of service and reimbursement would be eliminated. Under the current methodology, the most common reason for E & M audits has been a concern that physicians may be submitting claims with a higher code than is supported by the medical record; this is often referred to as “upcoding” and has resulted in overpayment demands or allegations that the physician has filed false claims.

In addition, CMS has proposed to adjust the new E & M reimbursement rate for three types of services that differ from traditional office visits. First, for separately identifiable E & M visits associated with a zero-day global procedure (such as an in-office surgical procedure), CMS would reduce the reimbursement for the least expensive procedure or visit on the same day as the separately identifiable E & M visit by 50 percent. Second, for office visits that concentrate on primary care services, CMS would create a new HCPCS code, GPC1X, which would increase the total reimbursement to reflect the face-to-face time spent with a patient. Third, CMS proposes to create a new add-on code, GCG0X, which would boost reimbursement for 10 specialties (including cardiology, rheumatology, hematology/oncology, and neurology) whose services are commonly billed using the Level 4 or 5 E & M visit code; this would reflect the additional complexity of their services and practice costs.

The proposed rule would treat psychiatric services differently from other medical services. CMS explained that psychiatric services would not be eligible to use one of the two proposed add-on codes for their face-to-face patient visits, as an existing CPT code, 90785, was created by the AMA to capture specific communications during a psychiatric visit or procedure. Nevertheless, CMS has proposed to add a new HCPCS code, GPR01, to allow for billing prolonged evaluation and management or psychotherapy services.

The Good and the Bad

On balance, the proposed rule offers a trade-off: in exchange for more flexibility in documenting the scope of an E & M service, some physicians may have to accept a net decrease in their overall Medicare Part B reimbursement for office-based services. However, the extent of the administrative simplicity offered by CMS may not be a case of “one size fits all” and may be limited by several factors. For example, those practices that find a time-based method attractive would need to ensure that they have the capabilities to accurately track physician time on a case-by-case basis. The proposed rule did not specify the form of capturing physician time but stated that if this proposal were adopted, it would monitor this change; that signals that CMS would be conducting audits to validate the accuracy of this method. Those that believe that the medical decision-making option is preferable will need to determine how best to document that process and how the physician arrived at a plan of care. In addition, the proposal to collapse the reimbursement for Levels 2 through 5 may not be a good fit for concierge medical practices, which are based on the concept of more face-to-face physician time.

CMS included estimates of the net impact on particular specialties of a shift to a single reimbursement rate for E & M Levels 2 through 5 and the availability of add-on codes. According to CMS’s projection, obstetrics/gynecology would experience a net increase of 4 percent, while specialties including rheumatology and dermatology would experience a net decrease of at least 3 percent. However, CMS did not provide data on the variations among specialty practices, so the impact on an individual practice may be difficult to forecast without a clear picture of the distribution of E & M Medicare claims.

It is far too early to predict whether audits by CMS contractors will decrease if the proposed rule becomes final, but one possible scenario is that audits may be more focused, and auditors may be less forgiving of missing or incomplete documentation.

Finally, the proposed rule is an attempt to work around the E & M codes themselves, which CMS cannot change. However, even if CMS adopts its proposal as a final rule, the stated goal of administrative simplicity may not be as robust as CMS envisions if physicians must still contend with varying levels of E & M documentation for the same service based on the policies of individual health plans.

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This Client Alert was authored by **Robert E. Wanerman.** *For additional information about the issues discussed in this Client Alert, please contact one of the authors or the Epstein Becker Green attorney who regularly handles your legal matters.*