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Part B Insider (Multispecialty) Coding Alert

Evaluation and Management: Specialty May Determine Pay Gains with CY 2019 MPFS Proposal

Hint: Suggested E/M documentation changes could balance shortcomings.

If a hefty portion of your Part B take-home pay is tied to E/M office visits, you may want to review recent Medicare proposals. However, depending on your specialty and the number of patients you see annually, you may be in for a pleasant surprise.

Background: On July 27, CMS published the Medicare Physician Fee Schedule (MPFS) for CY 2019 in the Federal Register with "historic" changes to E/M billing, payment, and documentation for office visit codes (99201-99215), according to the report. The long-awaited documentation proposals could be a boon to physician practices, easing past administrative burdens and allowing providers more say in the end game.

The CY 2019 MPFS proposals that may impact E/M documentation include the following:

- Use medical decision-making or time for outpatient E/M versus the current guidelines.
- Give physicians the option of using time as a factor even if counseling or care coordination don't dominate the time of the encounter.

Put re-documenting aside and let providers "focus their documentation on what has changed since the last visit or on pertinent items that have not changed."

- Give practitioners the option of accepting data plugged in by staff instead of timely re-entering.

"There is little doubt that efforts to reduce regulatory burdens and simplify the documentation requirements for E/M visits will be welcomed by physicians and hospitals," indicates attorney **Benjamin Fee, Esq.**, of **Dorsey and Whitney LLP** in the Des Moines, Iowa office. "The question though, is whether the proposed rule, or whatever rules are ultimately finalized, will actually have significant impact in practice."

Fee adds, "I think as individuals, systems, and representative associations continue to review the proposed rule, the reactions to the proposed rule will be mixed."

Are These Changes Too Good to Be True?

If you're wondering if there's a "catch," note that there is. The agency wants to cut back on "redundant processes" with its E/M documentation proposals and go to "a system with just one set of requirements" and utilize "one payment level each for new and established patients," said **Seema Verma**, CMS Administrator in a "Letter to Doctors" last month.

What that means: CMS wants to move from the current E/M payment structure to "single blended payment rates for new and established patients for office/outpatient E/M level 2 through 5 visits and a series of add-on codes to reflect resources involved in furnishing primary care and non-procedural specialty generally recognized services," the agency said in a fact sheet about the change.

The MPFS proposed rule payment level changes include:

- 99212-99215: $93 for each of these codes
- 99202-99205: $135 for each of these codes.

Positive outlook: This would mean that payments for office level five codes would go down, while pay for level two

codes would go up. Practices that report a lot of level five codes would be likely to lose money, but some practices would see gains, says **Cyndee Weston, CPC, CMC, CMRS**, executive director of the **American Medical Billing Association (AMBA)** in Davis, Oklahoma.

"Keep in mind also that with simplified documentation requirements, some practices might be able to see more patients," advises **Glenn D. Littenberg, MD, MACP, FASGE, AGAF**, a gastroenterologist and former CPT® Editorial Panel member in Pasadena, California. "The intention of CMS is for this change to be budget neutral overall."

Review These Examples of How Pay Could Change

To determine the impact that the policy might have on Medicare clinicians, Medicare Compliance and Reimbursement reviewed utilization data for two different types of practices: a rural primary care physician and an urban specialist. We estimated the use of the E/M codes based on past billing and payment data from CMS, calculating how the E/M changes would impact each of the providers if the changes were implemented.

These calculations assume that the physicians will earn $93 for each of the following codes under the proposal and do not include any of the proposed G-codes, nor appended modifiers and typical Medicare adjustments, which will alter the end payment. These are the current reimbursement non-facility payment rates for 99212-99215:

- 99212: $45
- 99213: $74
- 99214: $109
- 99215: $148

Impact to practice 1: Internist in rural Northern Ohio

99212: Billed 22 times in one year - worth $990 today, worth $2,046 under proposal
99213: Billed 1,286 times in one year - worth $95,164 today, worth $119,598 under proposal
99214: Billed 1,039 times in one year - worth $113,251 today, worth $96,627 under proposal
99215: Billed 42 times in one year - worth $6,216 today, worth $3,906 under proposal

Total difference: This internist earned $215,621 for these four codes under today's payment structure, and would earn $222,177 under the proposal. This physician would see **$6,556 more pay** under the proposal for these four codes.

Impact to Practice 2: Gastroenterologist in South Florida

99212: Billed 27 times in one year - worth $1,215 today, worth $2,511 under proposal
99213: Billed 170 times in one year - worth $12,580 today, worth $15,810 under proposal
99214: Billed 1,228 times in one year - worth $133,852 today, worth $114,204 under proposal
99215: Billed 187 times in one year - worth $27,676 today, worth $17,391 under proposal

Total difference: This gastroenterologist earned $175,323 for these four codes under today's payment structure, and would earn $149,916 under the proposal. This doctor would see **$25,407 less pay** under the proposal for these four codes.

Nothing Is Set in Stone … Yet

Remember, this is just a proposed rule, and the updates are not solidified. Still, the single payment facts speak for themselves, and some providers may be worried about the negative financial effects.

"We're hearing of specialties that are saying 'our patient population is so varied; a single level wouldn't work,'" says **Michael Granovsky, MD, FACEP, CPC**, president of **LogixHealth**, a national coding and billing company based in Bedford, Massachusetts. And for "those practices that see very high intensity patients such as a specialized oncologist or endocrinologist, it doesn't seem fair for them."

"Although some of these specialists may be able to take advantage of the proposed add-on codes, many will see a

significant reduction in Medicare payments related to E/M visits if the rule is finalized as proposed," stresses Fee. "The single payment rate will also certainly raise concerns about the possibility of the changes creating a disincentive for physicians to see Medicare patients with multiple chronic conditions."

More to come: It's important to remember that the E/M proposals originated from years-long stakeholder feedback, and CMS will accept and review public comments through Sept. 10, 2018 on the CY 2019 MPFS proposed rule. Part B Insider will continue to monitor and report on any changes as the agency moves to finalize proposals.

Resource: For a closer look at the published MPFS proposed rule for CY 2019 available in the Federal Register, visit www.federalregister.gov/documents/2018/07/27/2018-14985/medicare-program-revisions-to-payment-policies-under-the-physician-fee-schedule-and-other-revisions.