Major Changes Coming to the 2019 Physician Fee Schedule and Other Payment Policies?

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On July 27, 2018, the Centers for Medicare & Medicaid (CMS), published a Proposed Rule regarding significant modifications to Medicare payment policies under the Physician Fee Schedule (PFS) for Part B services rendered in CY 2019.

Touted as "major changes" to the PFS and other payment policies, the 1,472-page Proposed Rule includes changes to the documentation requirements for Evaluation and Management (E/M) services and the relative value of services (RVU) to accommodate changes in medical practice and reduce administrative burdens on practitioners.

Notably, with regard to the proposed changes to E&M services, CMS' proposal recognizes the evolving use of technology in medical practice and is proposing to add a separate payment for brief non-face-to-face interventions between a physician through communication technology to assess a patient's condition and determine if an office visit is necessary. Recognizing the broad range of technology available and its benefits on patient care, CMS is seeking comments from the medical community on the various types of communication technology currently being utilized, as well as collateral issues with such a process, such as frequency limitations, timeframes for when telecommunication visits would be separately billable versus bundled and, to name but a few of the policies under considerations.

CMS also proposes easing the administrative burdens on practitioners for E/M services through multi-step changes to the documentation requirements and payment policies currently in place. Among the initial changes being proposed are the following:

- Eliminating the requirement to document the medical necessity of an E/M Home Visit, as opposed to an office visit,

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leaving the determination to the practitioner and patient to make without additional rules.

- Modifying the documentation methods currently in place to determine the appropriate level of E/M visit by allowing the practitioner to choose a new Medical Decision Making (MDM) or time option, or continue utilizing the 1995 or 1997 E/M Guidelines currently in place. CMS is also seeking comments from practitioners on the sufficiency of the current 1995/1997 Guidelines and any modifications that should be made in light of current practices.
- Altering the reimbursement structure for E/M services from a 5-level payment system to only two levels, which would retain a Level 1 code but combine Level 2 through 5 into a single payment rate (with one rate for new and another rate for existing patients), with documentation requirements to meet what is the currently associated with a Level 2 visit for history, exam and/or MDM.
- Removing Redundancies in E/M documentation, such as Review of Systems (ROS) or pertinent family and/or social history previously noted in the record. For example, CMS proposes to simplify the documentation of exam and history for a patient by allowing the practitioner to simply note any changes since last visit or pertinent items that have not changed, rather than re-documenting a defined list of recurred elements. CMS is also proposing to remove the requirement that practitioners re-enter information, such as chief complaint and history that is entered into the record by ancillary staff for new and existing patients, instead allowing the practitioner to merely acknowledge review and verification of the entry.
- Proposing a number of corollary payment policies and rate-setting adjustments for E/M visits to reflect important distinctions between the kinds of visits furnished to Medicare beneficiaries, such as E/M multiple procedure payment adjustments (*i.e.*, instances of an E/visit and a same-day procedure); HCPCS G-Code add-ons to recognize additional resources needed for primary care and inherent visit complexities that require work beyond the level-2 through level-5 visits, G-codes for podiatric visits, additional prolonged face-to-face add-on G-code and technical modifications to Practice Expense (PE) methodology.

Other significant changes include the addition of a new G Code for Rural Health Centers (RHC) and Federally Qualified Health Centers (FQHC) for Virtual Communications with a patient for a medical condition unrelated to a services provided within the prior 7 days; changes to the documentation related to a teaching physician's participation in E/M services and modifications to the Physician Self-Referral Regulations to codify changes made to the writing and signature requirements for certain compensation arrangements in the Bipartisan Budget Act of 2018.

Given that documentation has always played a critical role in reimbursement and has increased in administrative burdens to practitioners, providers need to voice their concerns on these important changes to balance the need for sufficient documentation for continuity of patient care while accommodating the government's need to know what it is paying for and why.

Comments to the Proposed Rule are being accepted electronically or by mail through September 10, 2018. If you are interested in submitting comments, Butzel Long healthcare attorneys can assist in preparing your submission.

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