Calendar Year (CY) 2019 Medicare Physician Fee Schedule (PFS) Final Rule

Documentation and Payment for Evaluation and Management (E/M) Visits

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Patients Over Paperwork

- The **Patients Over Paperwork** initiative is focused on reducing administrative burden while improving care coordination, health outcomes and patients’ ability to make decisions about their own care.
- Physicians tell us they continue to struggle with excessive regulatory requirements and unnecessary paperwork that steal time from patient care.
- This Administration has listened and is taking action.
- The Physician Fee Schedule final rule addresses those problems by streamlining documentation requirements to focus on patient care and modernizing payment policies so seniors and others covered by Medicare can take advantage of the latest technologies to get the quality care they need.
Medical Record Documentation Supports Patient Care

- Clear and concise medical record documentation is critical to providing patients with quality care and is necessary for physicians and others to receive accurate and timely payment for furnished services.
- Medical records chronologically report the care a patient received and record pertinent facts, findings, and observations about the patient’s health history.
- Medical record documentation helps physicians and other health care professionals evaluate and plan the patient’s immediate treatment and monitor the patient’s health care over time.
- Many complain that notes written to comply with coding requirements do not support patient care and keep doctors away from patients.
Levels of E/M Visits and PFS Payment

- Physicians and other practitioners paid under the PFS bill for office/outpatient E/M visits using a set of CPT codes that distinguish visits based on level of complexity, site of service, and whether the patient is new or established.

- The three key components when selecting the appropriate code to bill are history, examination, and medical decision making (MDM). For visits that consist predominantly of counseling and/or coordination of care, time (in conjunction with MDM) can be used as the key or controlling factor determining visit level.

- There are currently five levels of E/M office/outpatient visits (reported using CPT codes 99201-99215). Payment increases with each level.
Choosing the Appropriate Code and Providing Supporting Documentation

• For coding and billing the PFS, practitioners may use either the 1995 or 1997 E/M documentation guidelines. These are very similar to a parallel set of guidelines present in the CPT codebook.

• These guidelines specify medical record information within each of the three components that serves as support for billing a given visit level.
Why Change?

• Stakeholders have said that the E/M documentation guidelines, and the code set itself are clinically outdated and may not reflect the most clinically meaningful or appropriate differences in patient complexity and care. Furthermore, the guidelines may not be reflective of changes in technology, or in particular, the way that electronic medical records have changed documentation and the patient's medical record.

• According to stakeholders, some aspects of required documentation are redundant

• Additionally, current documentation requirements may not account for changes in care delivery, such as a growing emphasis on team-based care, increases in the number of recognized chronic conditions, or increased emphasis on access to behavioral health care.
Final Policies for E/M Visits Starting in 2019

For 2019 and beyond, CMS finalized the following optional but broadly supported documentation changes for E/M visits, that do not require changes in coding/payment.

• Elimination of the requirement to document the medical necessity of a home visit in lieu of an office visit;

• For history and exam for established patient office/outpatient visits, when relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.
Final Policies for E/M Visits Starting in 2019 (cont.)

• Additionally, we are clarifying that for chief complaint and history for new and established patient office/outpatient visits, practitioners need not re-enter in the medical record information that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.
Policies for E/M Office/Outpatient Visits
Starting in 2021

• Beginning in CY 2021, CMS will implement payment, coding, and additional documentation changes for E/M office/outpatient visits, specifically:
  - Single rates for levels 2 through 4 for established and new patients, maintaining the payment rates for E/M office/outpatient visit level 5 in order to better account for the care and needs of complex patients;
  - Add-on codes for level 2 through 4 visits that describe the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care;
Policies for E/M Office/Outpatient Visits Starting in 2021 (cont.)

- A new “extended visit” add-on code for level 2 through 4 visits to account for the additional resources required when practitioners need to spend additional time with patients.

- For level 2 through 5 visits, choice to document using the current framework, MDM or time;
  - When time is used to document, practitioners will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary (typical CPT time for code reported, plus any extended/prolonged time).
  - When using current framework or MDM to document, for level 2 through 4 visits CMS will only require the supporting documentation currently associated with level 2 visits.
For Further Information

See the Physician Fee Schedule website at:

https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html