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What's Next for E/M Visits: Now and a Look Ahead

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AMERICAN OSTEOPATHIC ASSOCIATION

Get Ready for CMS Physician Fee Schedule (PFS) Changes for 2019 through 2021

Objectives

- Provide a brief history and perspective of Evaluation and Management (E/M) codes and documentation guidelines
- Understand CMS' rationale for implementing broad changes to reform physician payment for E/M codes and reduce administrative burden
- Learn about the E/M policy changes for 2019 and the payment and policy changes published 2021
- Highlight AOA advocacy efforts to ensure adequate payment for E/M services and reasonable regulatory changes

Current Evaluation and Management (E/M) Code Descriptors

- The descriptors for the levels of E/M services recognize seven components, six of which are used in defining the levels of E/M services. These components are:
  - History
  - Examination
  - Medical decision making
  - Counseling
  - Coordination of care
  - Nature of presenting problem
  - Time
- The first three of these components (ie, history, examination, and medical decision making) should be considered the **key** components in selecting the level of E/M services. An exception to this rule is in the case of visits that consist predominantly of counseling or coordination of care when time can be used
- The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service

Current Evaluation and Management (E/M) Code Descriptors con't

- **99213** - Office or other outpatient visit for the evaluation and management of an **established** patient, which requires at least **2 of these 3 key components**: An expanded problem focused **history**; An expanded problem focused **examination**; Medical decision **making** of low complexity. Counseling and coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, **15 minutes are spent face-to-face** with the patient and/or family

- **99203** - Office or other outpatient visit for the evaluation and management of a **new** patient, which requires these **3 key components**: A detailed **history**; A detailed **examination**; **Medical decision making** of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity. Typically, **30 minutes are spent face-to-face** with the patient and/or family

Medical Decision Making (MDM)

- Medical decision making grid, which weighs the type of decision making with:
- 1) Number and complexity of problems;
- 2) Amount and/or complexity of data and
- 3) Risk

Number of Diagnoses or Management Options	Amount and/or Complexity of Data to be Reviewed	Risk of Complications and/or Morbidity or Mortality	Type of Decision Making
minimal	minimal or none	minimal	straightforward
limited	limited	low	low complexity
multiple	moderate	moderate	moderate complexity
extensive	extensive	high	high complexity

2017 Medicare Data

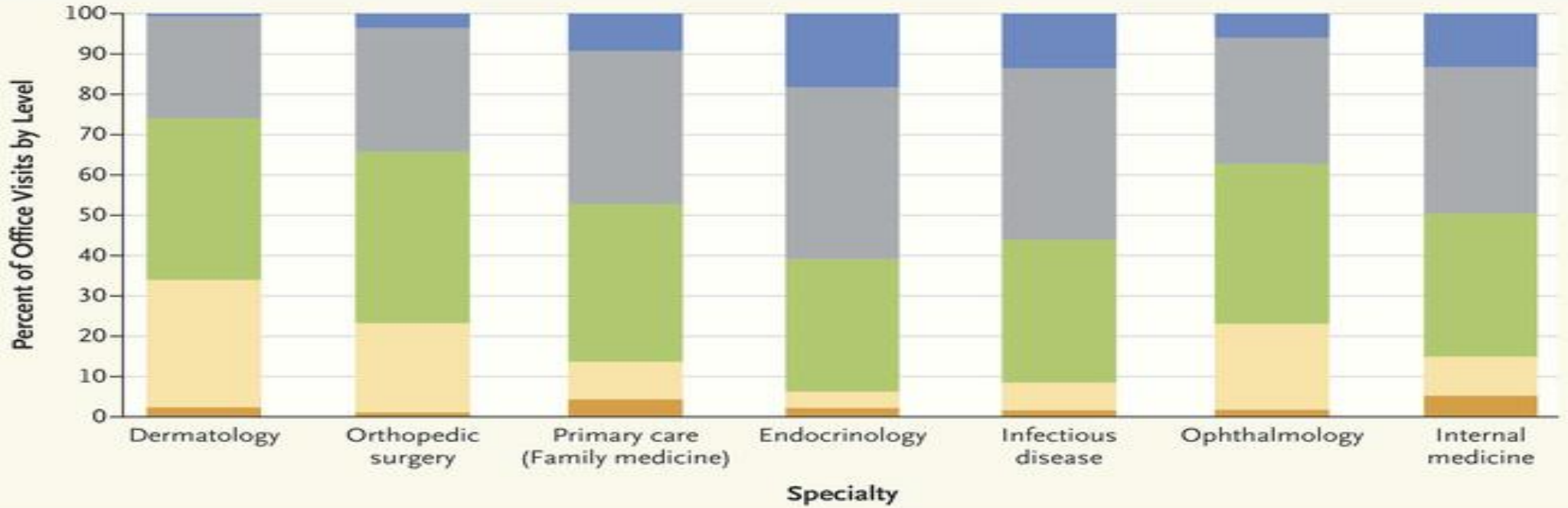
- E/M services account for 51% of all PFS spending ($48 billion)
- Office-based E/M services account for 20% of PFS spending ($24 billion)
- Utilization - number of reported services

99201 – 252,423	99211 – 3,884,402
99202 – 2,751,440	99212 – 12,807,980
99203 – 11,410,324	99213 – 98,201,339
99204 – 10,292,014	99214 – 103,181,579
99205 – 2,894,800	99215 – 10,042,159

Percentage of Specialty Medicare Charges from E/M

- Psychiatry-98%
- Geriatrics-93%
- ED-91%
- Family practice-85%
- Internal medicine 82%
- Rheumatology-64%
- Hematology-54%
- Neuology-62%
- GI-45%
- Dermatology-38%
- Cardiology-35%
- Ophthalmology-64%
- Ob-gyn-56%
- ENT-52%
- Hand, Plastics, GS-50%
- CV/Thoracic-44%

Medicare Payments and Levels of Service: Office Visits for Established Patients 2015



Variable							
Medicare office-visit payments per physician ($)	49,441	30,150	30,975	45,611	10,977	19,126	31,684
Share of Medicare payments from E&M codes (%)	22.4	23.1	70.8	70.3	80.2	5.3	74.9

History of E/M Codes and Documentation Guidelines

- 1992 – AMA introduces E/M codes to describe inpatient and outpatient visits into new resource-based relative value scale (RBRVS) system
- 1995 – CMS revised E/M services to include more specific details about the History and extent of Physical Exam
  - To be consistent with CPT code descriptors and definitions, and for uniform interpreted and application by users across the country
- 1995 – AMA in collaboration with CMS introduced the collaborative development of documentation guidelines
- 1997 – Documentation guidelines were revised to include single-specialty examinations

History of E/M Codes and Documentation Guidelines con't.

- 2000 – Extensive revisions were made by AMA and specialty societies, but were rejected by CMS
- 2007 – CMS revalued all E/M codes
- 2012 – CMS proposed to refer all E/M codes to the RUC for review as potentially misvalued
- 2013 – CPT developed new guidelines to redefined the Medical Decision Making (MDM) component of the codes, but CMS did not implemented the changes
- 2018 – CMS proposed broad changes to office/outpatient-based E/M codes (99201-99205 and 9921-99215) and payment

Why Change Now?

- Consensus in medical community that documentation guidelines are ambiguous, administratively burdensome, do not reflect the most clinically meaningful or appropriate differences in patient complexity and care, and are not updated for changes in technology, especially electronic health record (EHR) use
- Current documentation requirements do not account for changes in care delivery, such as a growing emphasis on team-based care, non-face-to-face care, increases in the number of recognized chronic conditions, or increased emphasis on access to behavioral health care
- Coding requirements are redundant and do not support patient care: The volume of documentation should not be the primary influence upon which a specific level of service is billed
- Documentation should support the level of service reported
- Increased number and cost of audits

Why Change Now? con't

- Prior attempts to revise E/M guidelines were unsuccessful or resulted in additional complexity due to lack of stakeholder consensus (with widely varying views among specialties), and differing perspectives on whether code revaluation would be necessary under the Physician Fee Schedule (PFS) as a result of revising the guidelines

- The E/M guidelines are used by many other payers, which have their own payment rules and audit protocols

- There is variation in how Medicare's own contractors (Medicare Administrative Contractors (MACs)) interpret and apply the guidelines as part of their audit processes

HHS Secretary Azar's Perspective

- Patients Over Paperwork Initiative
  - Focuses on reducing administrative burden while improving care coordination, health outcomes and patients' ability to make decisions about their own care.
- Greater Emphasis on Transition to Value-Based Payments
- Ongoing Efforts to Reduce Regulatory Burden

"As healthcare has grown more and more complex, the traditional model of paying doctors based on the volume of procedures they perform, as much of Medicare does, has made less and less sense," …HHS will write new guidance for laws that "stand in the way of healthcare providers" and hold back the healthcare system's transition to value-based care.

CMS Administrator Seema Verma's Perspective

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Dear Clinician,

CMS has been hard at work to address the burden placed on clinicians by federal health care regulations. Through our "Patients over Paperwork" initiative we are collecting feedback and updating policies in Medicare and Medicaid that are outdated, duplicative, or overly burdensome. Over the past year I have traveled the nation and met with clinicians, and the feedback I have heard has guided my efforts at the agency.

"clinicians find themselves having to perform and document clinical activity that may be of only marginal relevance to the visit, but is required in order to receive the level of payment that their effort deserves."

"…updating policies in Medicare and Medicaid that are outdated, duplicative, or overly burdensome

"…major source of burnout is the documentation burden associated with the evaluation and management (E/M) coding, and that a change is long overdue."

Physician Fee Schedule Final Rule 2019

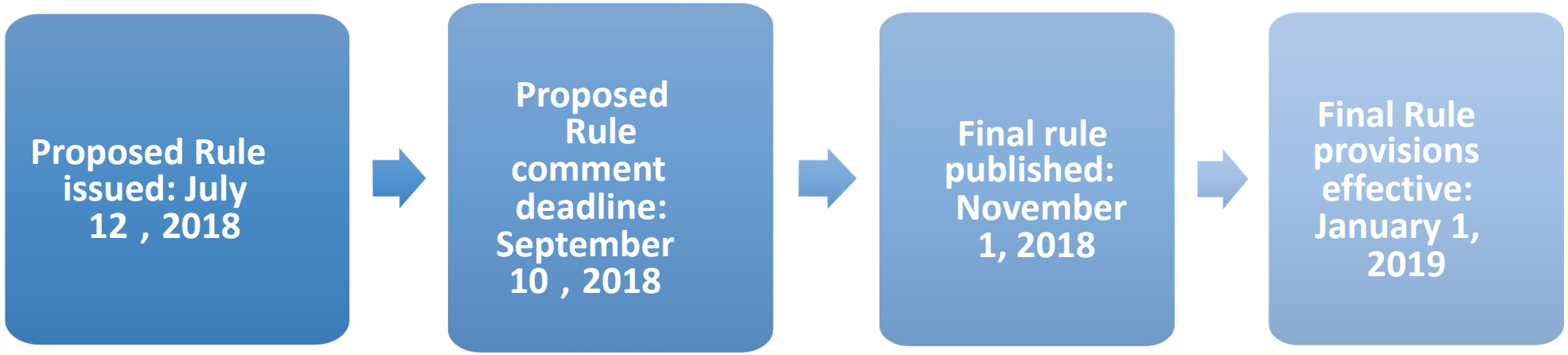
Federal Register / Vol. 83, No. 226 / Friday, November 23, 2018 / Rules and Regulations

Stakeholders have long maintained that all of the E/M documentation guidelines are administratively burdensome and outdated with respect to the practice of medicine.

…all of the E/M documentation guidelines are administratively burdensome and outdated with respect to the practice of medicine."

Pg. 59627

PFS Proposed and Final Rules Timeline



2019 Proposed Rule – PFS Changes to E/M Codes and Documentation Requirements

CMS' main objectives for reforming E/M codes are to:

1) Reduce Administrative Burden – consistent with Patient Over Paperwork Initiative

2) Collapse Payment for office/outpatient E/M services

2019 PFS Proposed Rule – Reduce Administrative Burden

- **Allow practitioners choice in documentation for office based E/M visits for Medicare PFS payment:**
  - Existing 1995 or 1997 documentation guidelines
  - Medical decision-making (MDM) only
  - Time spent face-to-face with patients
- **Eliminating Extra Documentation Requirements for Home Visits**
  - Remove the requirement that the medical record must document the medical necessity of furnishing the visit in the home rather than in the office
- **Eliminating Prohibition on Billing Same-day Visits**
  - Allow payment for two E/M visits billed by a physician in the same practice for the same beneficiary on the same day

2019 PFS Proposed Rule – Reduce Administrative Burden con't

- **Removing Redundancy in E/M Visit Documentation**
  - CMS proposes to expand the current policy that the billing provider is not required to repeat the documentation for "Review of Systems" and/or pertinent past, family, or social history (PFSH) obtained during an earlier encounter
  - If there is evidence that the provider reviewed/updated the information, they would not need to re-record the elements
  - Allow practitioners to review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than reentering it
- **Teaching Physician Documentation for E/M Services**
  - The presence of a teaching physician during the E/M service may be demonstrated by notes in the medical record made by a physician, resident or nurse

2019 PFS Proposed Rule – Payment Changes

- CMS proposed a single, blended payment rate for Office E/M codes levels 2 through 5 for established patients (99212-99215) and new patients (99202-99205). Documentation would have to meet Level 2 guidelines

- CMS proposed to make other adjustments through add-on payments for payment accuracy.

- Along with the changes to a single payment rate for E/M codes levels 2-5, CMS proposed three new add-on G-codes
  - Primary Care ~$5
  - Specialty care ~$14
  - New Prolonged E/M Service ~$67

Proposed Payments for Office/Outpatient-Based E/M Visits

Level	Current Payment* (established patient)	Proposed Payment**
1	$22	$24
2	$45	$93
3	$74	
4	$109	
5	$148	

Level	Current Payment* (new patient)	Proposed Payment**
1	$45	$44
2	$76	$135
3	$110	
4	$167	
5	$211	

*Current Payment for CY 2018
**Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate

Proposed add-on Codes for E/M Services

HCPCS code	Description	Total RVUs, office visit	Proposed payment rate for 2019, office visit
GPRO1	Prolonged E&M or psychotherapy service(s) (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service; 30 minutes	1.87	$67.41
GPC1X	Visit complexity inherent to E&M associated with primary medical care services that serve as the continuing focal point for all needed health care services	0.15	$5.41
GCG0X	Visit complexity inherent to E&M associated with endocrinology, rheumatology, hematology/oncology, urology, neurology, obstetrics/gynecology, allergy/immunology, otolaryngology, or interventional pain management–centered care	0.38	$13.70

2019 PFS Proposed Rule – Payment Changes con't

- **E/M Stand-alone and Global Periods Policy (Multiple Procedure Payment Reduction)**
  - Proposed to reduce payment by 50% for the least expensive procedure/visit that the same physician provides on same day as E&M service; using modifier -25
    - *This change would have severely impacted OMT services*
  - CMS noted that the MPPR reductions would be used to fund the new add-on payment for E/M codes

- **Single PE/HR value for E/M Visits – Indirect Practice Expense Category (IPCI)**
  - This change would also have resulted in the exclusion of the indirect practice costs for office visits when deriving every other specialty's indirect practice expense amount for all other services that they perform, which would have resulted in large payment cuts for many specialties

CMS Impact Estimates by Specialty

TABLE 95—ESTIMATED SPECIALTY LEVEL IMPACTS OF FINAL E/M PAYMENT AND CODING POLICIES IF IMPLEMENTED FOR 2019—Continued

Specialty	Allowed charges (mil)	Impact of work RVU changes %	Impact of PE RVU changes %	Impact of MP RVU changes %	Combined impact %
(A)	(B)	(C)	(D)	(E)	(F)
Geriatrics	197	−1	−1	0	−1
Hand Surgery	214	1	1	0	3
Hematology/Oncology	1,741	0	−1	0	0
Independent Laboratory	646	−1	3	0	3
Infectious Disease	649	−1	−1	0	−1
Internal Medicine	10,767	0	0	0	0
Interventional Pain Mgmt	868	1	2	0	3
Interventional Radiology	386	0	−2	0	−2
Multispecialty Clinic/Other Phys	149	−1	−1	0	−2
Nephrology	2,190	−1	−1	0	−2

AMA Proposed Impact Estimates by Specialty

Medicare Designated Specialty	Total Medicare Payment for Office Visits w/o Policy Changes (Using CY2018 Total RVUs)	Change in Payment Due To Proposed E/M Collapse Policy (includes G codes*)	Additional Change in Payment Due to E/M MPPR Policy	Net Change Due to E/M Collapse and E/M MPPR Policies	Total Medicare Payment for Office Visits Under Proposed Method (E/M Collapse and E/M MPPR) (Using Proposed CY2019 Total RVUs)	Percent Change in Payment for Office Visits (Both E/M Collapse and E/M MPPR Policies)
TOTAL	$ 23,298,623,446					
HOSPICE AND PALLIATIVE MEDICINE	$ 6,491,871	$ (1,278,816)	$ (21,072)	$ (1,299,888)	$ 5,191,983	-20%
HEMATOLOGY	$ 35,814,877	$ (5,616,074)	$ (76,952)	$ (5,693,026)	$ 30,121,850	-16%
GYNECOLOGY/ONCOLOGY	$ 28,857,336	$ (3,997,258)	$ (547,163)	$ (4,544,421)	$ 24,312,915	-16%
MEDICAL ONCOLOGY	$ 217,094,796	$ (31,098,224)	$ (182,736)	$ (31,280,960)	$ 185,813,836	-14%
NEUROPSYCHIATRY	$ 3,342,298	$ (410,887)	$ (23,423)	$ (434,310)	$ 2,907,988	-13%
NEPHROLOGY	$ 366,158,222	$ (47,203,589)	$ (302,888)	$ (47,506,478)	$ 318,651,744	-13%
NUCLEAR MEDICINE	$ 3,261,367	$ (405,925)	$ (12,208)	$ (418,133)	$ 2,843,234	-13%
CARDIAC ELECTROPHYSIOLOGY	$ 123,640,581	$ (15,324,933)	$ (146,856)	$ (15,471,789)	$ 108,168,792	-13%
CRITICAL CARE (INTENSIVISTS)	$ 35,990,339	$ (4,325,639)	$ (100,505)	$ (4,426,144)	$ 31,564,195	-12%
RADIATION ONCOLOGY	$ 85,243,662	$ (9,893,434)	$ (574,960)	$ (10,468,394)	$ 74,775,268	-12%

AMA Proposed Impact Estimates by Specialty con't

Medicare Designated Specialty	Total Medicare Payment for Office Visits w/o Policy Changes (Using CY2018 Total RVUs)	Change in Payment Due To Proposed E/M Collapse Policy (includes G codes*)	Additional Change in Payment Due to E/M MPPR Policy	Net Change Due to E/M Collapse and E/M MPPR Policies	Total Medicare Payment for Office Visits Under Proposed Method (E/M Collapse and E/M MPPR) (Using Proposed CY2019 Total RVUs)	Percent Change in Payment for Office Visits (Both E/M Collapse and E/M MPPR Policies)
INTERNAL MEDICINE	$ 3,871,679,750	$ 31,325,279	$ (24,729,341)	$ 6,595,938	$ 3,878,275,688	0%
FAMILY MEDICINE	$ 3,606,747,571	$ 113,138,550	$ (56,711,076)	$ 56,427,473	$ 3,663,175,044	2%
OSTEOPATHIC MANIPULATIVE MEDICINE	$ 20,490,031	$ 761,315	$ (365,507)	$ 395,808	$ 20,885,840	2%
OPTOMETRY	$ 273,100,554	$ 26,752,277	$ (1,697,949)	$ 25,054,327	$ 298,154,881	9%
INTERVENTIONAL PAIN MANAGEMENT	$ 168,203,323	$ 22,545,559	$ (6,788,185)	$ 15,757,374	$ 183,960,697	9%
PLASTIC AND RECONSTRUCTIVE SURGERY	$ 55,565,227	$ 10,280,479	$ (4,526,105)	$ 5,754,374	$ 61,319,601	10%
UROLOGY	$ 752,497,473	$ 126,343,272	$ (41,574,022)	$ 84,769,250	$ 837,266,723	11%
ALLERGY/IMMUNOLOGY	$ 95,801,235	$ 13,194,385	$ (603,585)	$ 12,590,800	$ 108,392,035	13%
CERTIFIED NURSE MIDWIFE	$ 2,144,561	$ 312,479	$ (20,735)	$ 291,744	$ 2,436,305	14%
OBSTETRICS/GYNECOLOGY	$ 225,275,520	$ 47,309,295	$ (9,018,841)	$ 38,290,454	$ 263,565,974	17%
MAXILLOFACIAL SURGERY	$ 4,558,435	$ 978,386	$ (146,599)	$ 831,787	$ 5,390,222	18%
OPTOMETRY	$ 273,100,554	$ 26,752,277	$ (1,697,949)	$ 25,054,327	$ 298,154,881	9%
INTERVENTIONAL PAIN MANAGEMENT	$ 168,203,323	$ 22,545,559	$ (6,788,185)	$ 15,757,374	$ 183,960,697	9%

Medicare Designated Specialties with a +/- 10 percent Change in IPCI

Medicare Designated Specialty	Percent Change in Specialty IPCI
66 - Rheumatology	-39%
03 - Allergy/immunology	-36%
90 - Medical oncology	-27%
76 - Peripheral vascular disease	-23%
C0 - Sleep Medicine	-21%
83 - Hematology/oncology	-20%
19 - Oral surgery (dentists only)	-19%
09 - Interventional Pain Management	-17%
04 - Otolaryngology	-15%
72 - Pain management	-15%
07 - Dermatology	-12%
34 - Urology	-10%
77 - Vascular surgery	-10%
08 - Family practice	10%
71 - Registered Dietician/Nutrition Professional	11%
11 - Internal medicine	13%
26 - Psychiatry	17%
79 - Addiction medicine	24%

Challenges with CMS' Proposal

- Implementation in 2019 is not feasible
- Significant redistribution of payments
- Fee cuts for levels 4 and 5 visits and increases for levels 2 and 3 visits
- Incentive to conduct shorter, repeated visits would be heightened
- Risk to Medicare beneficiaries with most complex medical needs
- May exacerbate workforce deficiencies
- Threat to relativity within the RBRVS system
- MPPR reduction not consistent with current valuation

Challenges with CMS' Proposal con't

- IPCI adds to cuts in other services
- Add-on G codes and their documentation not well defined
- Inconsistency with commercial payers – 2 sets of rules adds to burden
- Concern about precedent to collapse payments to other families of E/M services
- Violation of the Social Security Act
- Administrative burden reduction may not be easily mitigated
- Documentation also needed to justify additional services, DME, participation in risk-adjusted payment models

AOA Response to the Proposed E/M Changes

- Change is needed – CMS' proposal and status quo are not acceptable
- Joined in discussions with a coalition of ~45 other specialty societies and participated in collaborative responses to CMS and Congress
- Included analysis of the financial impact on specialties and individuals, and
- Held in-person meetings with CMS Administrator and HHS senior staff
- Initiated a grassroots sign-on campaign – more than 1,500 DOs sent letters to CMS
- Participated in a CPT/RUC Workgroup organized to redefine office/outpatient-based E/M codes and documentation guidelines that would:
  - Decrease administrative burden of documentation and coding
  - Decrease unnecessary documentation in the medical record that is not needed for patient care
  - Decrease the need for audits
  - Ensure payment for E/M codes are resource-based and there is no direct goal for payment redistribution between specialties.

AOA Response to the Proposed E/M Changes con't

- Supported the proposals to reduce administrative burden
- Supported revising definitions and guidelines to eliminate history and exam as principle determinants in code level selection
- Medical decision making (MDM) documentation is the most important component of documentation and the criteria for MDM should be redefined
- Opposed the proposed payment changes for office/outpatient-based E/M's
  - Would result in reduced payments for the most complex patients
  - Wide variation in physician payments – majority are negative

Documentation Changes Effective Jan. 1, 2019

CMS finalized several changes to E/M documentation guidelines which were strongly supported by the AOA that remove restrictions on E/M coding but 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;
- Physicians will no longer be required to re-record elements of history and physical exam when there is evidence that the information has been reviewed and updated
- Physicians must only document that they reviewed and verified information regarding the chief complaint and history that is already recorded by ancillary staff or the patient

CMS estimates that these changes will reduce clinician regulatory burdens associated with E/M documentation by $84 million in 2019

Payment Changes to Take Effect Jan. 1, 2021

- CMS finalized its intention to implement the same single payment rate for levels 2 through 4 for established and new office patients
- Maintain the payment rates for E/M office/outpatient visit level 5 to account for the care and needs of complex patients
- For level 2 through 5 visits, choice to document using the current framework, MDM or 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

Payment Changes to Take Effect Jan. 1, 2021 con't

- In addition, CMS will implement new add-on G-codes for:
  - Primary care services;
  - Inherently complex specialty E/M visits;
  - Extended visits.
- These add-on codes would only apply to CPT codes 99202-99204 and 99212-99214.

- AMA estimates the implementation of the add-on codes would lead to an offset to the conversion factor of -2%.

2021 E/M Payment Amounts

		Current (2018) Payment Amount			Revised Payment Amount***		
	Complexity Level under CPT	Visit Code Alone*	Visit Code Alone Payment	Visit Code With Either Primary or specialized care add-on code**	Visit Code with New Extended Services Code (Minutes Required to Bill)	Visit with Both Add-on and Extended Services Code Added**	Current Prolonged Code Added (Minutes Required to Bill)*
New Patient	Level 2	$76	$130	$143	$197 (at 38 minutes)	$210	
	Level 3	$110					
	Level 4	$167					
	Level 5	$211	$211				$344 (at 90 minutes)
Established Patient	Level 2	$45	$90	$103	$157 (at 34 minutes)	$170	
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				$281 (at 70 minutes)

*This is not a new code. The current prolonged service code, describing 60 minutes of additional time but billable after 31 minutes of additional time, is only billed approximately once per one thousand visit codes reported. It is paid at approximately $133.

**In cases where one could bill both the primary and specialized care add-on, there would be an additional $13.
***The dollar amounts included in this projection are based on 2019 payment rates; actual amounts in 2021 when the policy takes effect will differ.

CMS' Reaction to AOA and Other Stakeholder Opposition to Proposed E/M Changes

- CMS will not finalize the Collapsed payment proposal for CY 2019 with the Office code structure and documentation guidelines remaining the same
- The following policies were also opposed by the AOA and will not be implemented by CMS:
- Payment reductions by 50% for office visits that occur on the same date as procedures (or a physician in the same group practice). The AOA brought attention to the fact that duplicative resources have already been removed from the underlying procedure through the current valuation process
- The proposed IPCI for the E/M office visits was withdrawn. AOA and AMA argued that overriding the current PE methodology for these services by treating Office E/M as a separate Medicare Designated Specialty which would have resulted in large payment cuts for many specialties

AMA Estimated Impact of 2021 Office E/M Payment Collapse CPT Codes 99201-99215

Medicare Designated Specialty	Total Estimated Medicare Payment for Office Visits for CY2019	Total Estimated Medicare Payment for Office Visits Collapsing Level 2-4 Only (CY2021)	Percent Change in Office Visit Payment (Collapsing Payment for Levels 2-4 Only)	Add-on G Codes Medicare Payment Estimate (GPC1X and GCG0X)	Approximate Impact of -2.4 Percent Conversion Factor/ RVU Adjustment to Offset GPC1X and GCG0X
CARDIOLOGY	$ 1,683,175,918	$ 1,539,957,598	-9%	$ 202,033,721	$ (132,979,742)
CRITICAL CARE (INTENSIVISTS)	$ 36,134,578	$ 33,467,605	-7%		$ (8,453,489)
ENDOCRINOLOGY	$ 376,157,895	$ 337,698,043	-10%	$ 43,540,306	$ (12,357,319)
FAMILY MEDICINE	$ 3,634,810,233	$ 3,518,168,727	-3%	$ 508,582,405	$ (157,968,190)
GASTROENTEROLOGY	$ 496,814,262	$ 488,459,983	-2%		$ (41,174,302)
GERIATRIC MEDICINE	$ 62,903,100	$ 58,134,025	-8%	$ 7,449,852	$ (4,742,957)
HOSPICE AND PALLIATIVE MEDICINE	$ 6,495,913	$ 6,194,451	-5%	$ 583,646	$ (983,571)
INFECTIOUS DISEASE	$ 87,352,895	$ 84,159,088	-4%	$ 10,830,063	$ (15,853,812)
INTERNAL MEDICINE	$ 3,900,244,206	$ 3,741,274,335	-4%	$ 523,592,121	$ (264,031,332)
INTERVENTIONAL CARDIOLOGY	$ 232,144,948	$ 211,624,802	-9%		$ (22,019,994)
INTERVENTIONAL PAIN MANAGEMENT	$ 169,422,386	$ 165,425,835	-2%	$ 23,474,448	$ (10,834,154)
NEPHROLOGY	$ 367,949,958	$ 335,948,629	-9%	$ 41,786,439	$ (53,118,229)
NEUROLOGY	$ 672,663,831	$ 624,593,663	-7%	$ 65,034,030	$ (37,059,286)
RHEUMATOLOGY	$ 377,456,606	$ 347,213,918	-8%	$ 46,314,201	$ (13,510,736)

AMA Estimated Impact of 2021 Office E/M Payment Collapse CPT Codes 99201-99215 con't

Medicare Designated Specialty	Total Estimated Medicare Payment for Office Visits for CY2019	Total Estimated Medicare Payment for Office Visits Collapsing Level 2-4 Only (CY2021)	Percent Change in Office Visit Payment (Collapsing Payment for Levels 2-4 Only)	Add-on G Codes Medicare Payment Estimate (GPC1X and GCG0X)	Approximate Impact of -2.4 Percent Conversion Factor/ RVU Adjustment to Offset GPC1X and GCG0X
CERTIFIED NURSE MIDWIFE	$ 2,542,267	$ 2,869,682	**13%**		$ (132,081)
COLORECTAL SURGERY (PROCTOLOGY)	$ 32,744,893	$ 35,471,863	**8%**		$ (4,067,461)
DERMATOLOGY	$ 892,877,725	$ 1,069,421,380	**20%**		$ (89,324,392)
DIAGNOSTIC RADIOLOGY	$ 12,295,073	$ 13,454,446	**9%**		$ (124,260,075)
GENERAL SURGERY	$ 332,581,560	$ 361,584,549	**9%**		$ (48,984,000)
HAND SURGERY	$ 62,337,124	$ 70,968,047	**14%**		$ (5,286,793)
INTERVENTIONAL RADIOLOGY	$ 9,530,144	$ 10,109,688	**6%**		$ (9,508,396)
MAXILLOFACIAL SURGERY	$ 4,585,779	$ 5,543,234	**21%**		$ (449,459)
OBSTETRICS/GYNECOLOGY	$ 226,871,578	$ 240,247,403	**6%**	$ 32,275,120	$ (13,775,207)
ORAL SURGERY	$ 8,560,373	$ 9,449,205	**10%**		$ (1,354,414)
ORTHOPEDIC SURGERY	$ 954,634,897	$ 1,052,774,904	**10%**		$ (91,803,186)
OSTEOPATHIC MANIPULATIVE MEDICINE	$ 20,655,982	$ 21,319,269	**3%**		$ (1,210,579)
PLASTIC AND RECONSTRUCTIVE SURGERY	$ 55,840,493	$ 65,682,818	**18%**		$ (9,141,277)
PODIATRY	$ 652,741,065	$ 839,440,692	**29%**		$ (52,017,080)

What Is The Future of E/M Documentation and Payment?

Page 584 of the final rule, CMS states:

“We recognize that many commenters, including the AMA, the RUC, and specialties that participate as members in those committees, have stated intentions of the AMA and the CPT Editorial Panel to revisit coding for E/M office/outpatient services in the immediate future.

We note that the 2-year delay in implementation will provide the opportunity for us to respond to the work done by the AMA and the CPT Editorial Panel, as well as other stakeholders.

We will consider any changes that are made to CPT coding for E/M services, and recommendations regarding appropriate valuation of new or revised codes.”

Also, CMS stated they will allow time for consideration of the findings of certain demonstrations and other initiatives to provide improved information for the valuation of chronic care management, primary care, and care transitions.

Next Steps to Reform E/M Codes

- AOA will continue working with the Coalition of Specialties to:
  - Re-engineer the methodology CMS used to determine the proposed collapsed payment
  - Perform impact analysis of financial impact by specialty and by individual of proposed collapsed payment
  - Model coding and payment alternatives to the CMS proposal to include data and impact analysis options driven by consensus of all involved
  - Understand the true financial impact on physician payments when major changes are being implemented
- Coordinate efforts with AMA CPT/RUC Workgroup who have completed an extensive revision of the office/outpatient E/M code descriptors in the CPT Manual that place Time or MDM as the basis for code level selection. Efforts include:
  - Refinement and simplification of the MDM grid
  - Redefining “Time” as total time spent on the day of the procedure
  - Submission of a Code Change Proposal for review by the CPT Editorial Panel in February, 2019, which could possibly take effect Jan 1, 2020. If the changes are approved, revaluation of the E/M codes may be necessary

Unanswered Questions/Concerns

- If CMS persists in collapsing payment rates for the office/outpatient-based E/M's will they then proceed to do the same with all other E/M services?
- Will there be additional disruptive changes in payment methodology for other code families in the PFS??
- How will the private payers respond to these changes?

The AOA and all of the physician medical community needs to remain vigilant and work collaboratively with CMS and Congress to not only represent and protect our members but more importantly our patients ability to receive high quality, cost effective care.

QUESTIONS?

Resources

See the Physician Fee Schedule website at:

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

or

contact the AOA

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