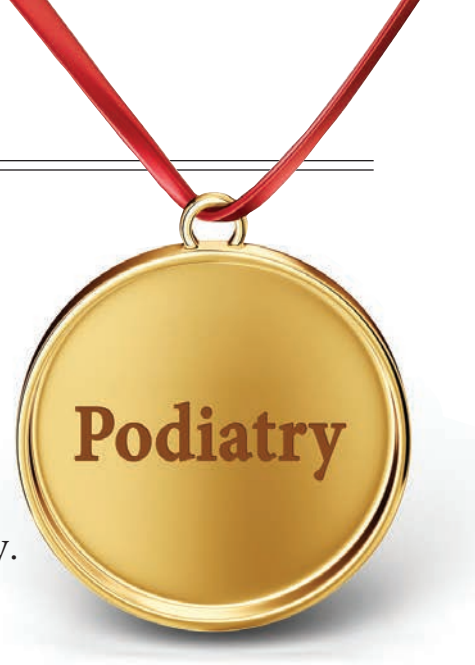
What Happened with the E/M Thing?



Here's a behind-the-scenes look at podiatry's biggest victory.

BY JEFFREY LEHRMAN, DPM

What Was Proposed

In the 2019 Medicare Proposed Physician Fee Schedule, CMS made several concerning proposals, three of which we will cover here. The first was to consolidate reimbursement for office-based and outpatient evaluation and management (E/M) visit levels 2 through 5 (i.e., CPT codes 99202 through 99205 for new patients and CPT codes 99212 through 99215 for established patients) into a single payment rate for new patients and established patients, respectively, regardless of which code is billed. This has been incorrectly stated as a "collapse of E/M codes". There was never a proposal to collapse the codes. The codes were not going to change, but rather this would have been a collapse of payments. For example, this would have meant that CPT 99204 and CPT 99202 would reimburse the same amount.

The second proposal was to single out podiatric physicians with new separate "podiatric E/M codes" developed by CMS. These codes would require the same documentation and performance thresholds as the standard E/M codes, but reimburse at a significantly lower rate, despite representing the same evaluation and management services that all other physicians furnish. The third proposal of particular concern was to reduce payment when separately identifiable evaluation and management (E/M) office and outpatient visits are furnished on the same day as procedures.

The Response

CMS received a resounding response to these proposals. These responses were provided in the form of comment letters, in-person meetings between CMS and stakeholders, as well as bipartisan comments to CMS from both the United States House of Representatives and the United States Senate. The majority of commenters asked CMS to not consolidate payment for office-based and outpatient E/M visit levels 2 through 5 to just one level for new patient E/Ms and one level for established patient E/Ms. Commenters explained that this would impact payment accuracy and not appropriately recognize more complicated encounters. Many commenters also indicated that finalizing these proposals would undermine the CPT and RUC process. The CPT Editorial Panel goes through an arduous, multi-step process to create codes. This process includes peer-reviewed literature and input from many different stakeholders. The RUC goes through a similarly intensive process to value these codes.

There was also robust opposition to creating new podiatry-specific E/M codes that would require the same documentation but reimburse at a significantly lower rate, despite being the same evaluation and management services that all other physician types furnish. This opposition came from national, state, and local podiatry organizations. It also came from non-podiatry organizations which recognized that this was not fair and would establish a dangerous precedent. Representatives from APMA met with many Congressional offices, including members from both parties of both the House Ways and Means Committee and the Senate Finance Committee. These meetings helped facilitate bipartisan-authored letters from both the U.S. House and the U.S. Senate asking CMS to not create new podiatry-specific E/M codes.

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The letter from the House enjoyed sign-on by 21% of House Representatives and the letter from the Senate had signatures from 24% of the country's Senators. Beyond what any society did, perhaps the response from individuals to this proposal garnered the most attention. APMA created an eAdvocacy website that made it easy for anyone to both submit comments on this proposal and to communicate with local legislators regarding concerns with this

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proposal. Over 11,000 people took advantage of this tool, including over 6,000 podiatrists, over 1,500 podiatry students, and over 3,000 others including patients, family, and other interested parties.

Finally, CMS also received abundant feedback regarding concerns with the proposal to reduce payment when separately identifiable (E/M) office and outpatient visits are furnished on the same day as procedures. This feedback included an explanation of separately identifiable E/M's, the CPT 25 modifier, and the importance of respecting the -25 modifier. This was not a budget neutral proposal and feedback also referenced payment accuracy and the fact that the RUC already considers procedures that normally accompany E/M services when determining value.

What Happened

Fortunately, none of these three proposals were finalized. For all of 2019 and 2020, we will continue to use the CMS 1995 and 1997 Documentation Guidelines for Evaluation and Management Services to determine E/M levels. However, some of the E/M documentation requirements changed effective January 1, 2019. For established patients, providers can focus documentation on what has changed since the last visit and do not need to re-record any of the unchanged, required E/M elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. For both new and established patients, providers do not need to re-enter in the medical record information regarding the patient's chief complaint and history that has already been entered by staff or the patient if the provider indicates in the medical record that he or she reviewed and verified this information. Continuing with the changes to documentation requirements for E/M services, teaching physicians no longer need to make notations in medical records that have previously been included by residents or other members of the medical team. Finally, it is no longer required to document the medical necessity of a home visit in lieu of an office visit.

The proposal to collapse payment for certain E/M services was modified with its implementation delayed until January 1, 2021. Level five E/M services will not be included. Starting January 1, 2021 new office and outpatient E/M services CPT 99202, 99203, and 99204 will all reimburse at a single payment rate. This rate will fall between what would have been the payment for CPT 99203 and 99204 in 2021. Similarly, established office and outpatient E/M services CPT 99212, 99213, and 9924 will all reimburse at a single payment rate that will fall between what would have been the 2021 payment for CPT 99213 and 99214. The documentation threshold requirements for E/M services will change in 2021. Starting January 1, 2021, the selection of level for both new and established office and outpatient E/M services levels 2-5 may be made based on either medical decision-making or time, or the 1995/1997 Documentation Guidelines for Evaluation and Management Services. When using medical decision-making or the 1995/1997 Guidelines to determine the level of an office/outpatient E/M service, if the level is between two and four, one will only need to reach the current level two thresholds.

CMS also did not finalize its proposal to create new, podiatry-specific E/M codes. This is not a temporary decision. The Final Rule states, "Based on our consideration of the information presented by commenters, we are persuaded that there could be a perceived devaluation of the breadth and value of care associated with podiatric visits by use of separate coding for these visits. Given these potential negative consequences, we are not finalizing the proposal to adopt separate coding for podiatric E/M visits." There will not be new, separate E/M codes for podiatrists, and podiatrists will continue to use the same E/M codes as all other physicians.

Finally, CMS did not finalize its proposal to reduce payment when separately identifiable E/M office and outpatient visits are furnished on the same day as procedures. It is noteworthy that this was even being considered. This should serve as a reminder that an E/M should not be submitted along with a procedure unless the documentation supports that the E/M was separately identifiable and medically necessary.

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The fact that these three proposals were not finalized is encouraging because it demonstrates that comments were recognized and respected. All those who advocated, submitted comments, and/or reached out to their Representatives and Senators are to be congratulated. **PM**

Resources

Revisions to Payment Policies under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; Medicaid Promoting Interoperability Program; etc.

https://www.federalregister.gov/public-inspection/current

Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019

https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year

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