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HEALTHCARE

INDUSTRY UPDATE: CMS DELAYS CHANGES TO E/M CODES

BACKGROUND

As regulations change to create a healthcare system that results in better accessibility, quality and affordability, the Centers for Medicare & Medicaid Services (CMS) issued a final rule on November 1, 2018, for services provided under the Medicare Physician Fee Schedule (PFS) on or after January 1, 2019.

Payment under the Medicare PFS is made for office visits, surgical procedures, diagnostic tests, therapy services, and specified preventative service utilizing evaluation and management (E/M) codes. To create a more streamlined and clinician-friendly code set, CMS reviewed these codes and is finalizing several documentation, coding, and payment changes to improve payment accuracy and reduce administrative burden.

In the final rule, CMS delayed making any changes to the E/M code set until 2021, though there are several documentation policy updates to reduce immediate burden in calendar year 2019 and 2020. CMS believes these updated changes will give providers the opportunity to focus on what is clinically relevant and medically necessary for the patient.[1]

CAUSE OF THE DELAY

Thousands of physicians submitted comments opposing proposed changes to E/M levels, suggesting they would penalize doctors who see more complex patients.[2] For instance, one physician group said doctors would be paid the same amount for office visits to evaluate patients with a common cold as those for a complicated neurological disorder. CMS responded by stating fewer codes will decrease coding time and increase physician productivity, saving 51 hours of administrative time per clinician per year.[3]

"The proposal has generated a groundswell of opposition from nearly every health professional organization in the country, including those whose members are projected to see increases in their Medicare payments."[4]

/ JAMES L. MADARA, MD
CEO, AMERICAN MEDICAL ASSOCIATION

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1. CMS, "Final Policy, Payment, and Quality Provisions Changes to the Medicare Physician Fee Schedule for Calendar Year 2019," November 1, 2018, https://www.cms.gov/newsroom/fact-sheets/final-policy-payment-and-quality-provisions-changes-medicare-physician-fee-schedule-calendar-year.
2. Joanne Finnegan, "Doctors speak out: CMS gets 15,314 comments on proposed physician Medicare changes," Fierce Healthcare, September 11, 2018, https://www.fiercehealthcare.com/practices/doctors-speak-out-cms-gets-15-314-comments-proposed-physician-medicare-changes.
3. Joanne Finnegan, "Good or bad idea? Some worry that E/M coding update could underpay doctors with sickest patients," Fierce Healthcare, July 18, 2018, https://www.fiercehealthcare.com/e-m-coding-update-underpay-doctors-ehr-cms-seema-verma.
4. John Madara, MD, "Re: File Code CMS–1693–P; Medicare Program: Medicare Program; 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; and Medicaid Promoting Interoperability Program," Received by CMS Administrator Seema Verma, September 10, 2018, https://searchlf.ama-assn.org/undefined/documentDownload?uri=%2Funstructured%2Fbinary%2Fletter%2FLETTERS%2F2018-9-10-2019-PFS-QPP-Comment-Letter-FINAL-2.pdf.

CONTACTS

RAJIV SHETH
Director
+1.312.685.1065
rajiv.sheth@navigant.com

DANIEL MUJICA
Managing Consultant
+1.913.232.6012
daniel.mujica@navigant.com

navigant.com

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IMPACT

At this time, no changes will be made to the E/M code set. However, several physician groups and associations, including the American Medical Association, have motioned to make recommendations to CMS on the future code changes. Physicians can engage with CMS to discuss refining the final policies for 2021.

NEXT STEPS

Organizations should use the next two years to determine how the changes might impact their physicians, patients, and bottom line, particularly for the proposed changes outlined below:

- **Paying a single rate for levels 2 through 4** for established and new patients while maintaining the payment rate for E/M office/outpatient visit levels 1 and 5, potentially affecting overall physician reimbursement.
- **Implementing add-on codes** that describe the additional resources required for services reported under E/M office/outpatient level 2 through 4 visits. Though most relevant for primary care and specific kinds of non-procedural specialized medical care, they would not be restricted by physician specialty.
- **Permitting practitioners to use medical decision-making, or time,** with less restrictions, to document E/M levels instead of applying current E/M guidelines.

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