

Special Commentary

What is CMS' True Motive Behind the Dramatic Proposed Changes to the Evaluation & Management Documentation Guidelines and Related Reimbursement Amounts?

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Abstract

All non-invasive services rendered by a health care provider, especially physicians and mid-level providers, are “coded” for billing/reimbursement purposes using a five-digit Evaluation and Management (“E&M”) code based on the Current Procedural Terminology (“CPT”) established by the American Medical Association (AMA). These codes, in place since 1995, are updated annually by the AMA and are tied to actual monetary reimbursement from both Medicare/Medicaid as well as from most commercial insurers.

During the summer of 2018, the U.S. Centers for Medicare and Medicaid Services (“CMS”) proposed major changes to some of the most common E&M codes that relate to patient visits to various types of physicians’ offices. The number of such codes changed but, of greater consequence, so did the reimbursement amounts, with many specialist physicians slated to incur marked reductions in compensation for their services. The author, a Certified Professional Coder of longstanding, asserts that the proposed changes are much more than “housekeeping” details, and she validates the concerns of numerous medical specialty associations that the net effect of these proposed changes would be to disincentivize large numbers of specialty physicians from treating Medicare and other patients. In fact, if these proposals are implemented it may no longer make economic sense for many specialty physicians to remain in practice. Is this the kind of result that the U.S. Government wants?

All CPT codes require documentation to support the medical necessity of the service(s) provided. E&M codes are comprised of “3 key components”: History, Exam, and Medical Decision Making. Within CPT, the E&M codes have anywhere from 1-5 different levels of service and each level requires a specified amount of the 3 key components to be completed. In 1995, the Centers for Medicare and Medicaid Services (CMS), formerly Health Care Financing Administration (HCFA), created the first set of E&M documentation guidelines. In 1997, a new set of guidelines were created that include a bullet-point system of 11 single-system organ exams.

The 1997 guidelines were extremely difficult to deal with in regards to the higher complexity of the different E&M levels. For example, the following page contains the table for the Hematologic/Lymphatic/Immunologic exam under the 1997 guidelines, showing the complexity of such documentation. There are 9 organ systems required with specific bullet points that must be met in order to reach a “comprehensive” level of exam and then to apply for reimbursement.

Hematologic/Lymphatic/Immunologic Examination

System/Body Area	Elements of Examination
Constitutional	<ul style="list-style-type: none"> • Measurement of any three of the following seven vital signs: 1) sitting or standing blood pressure, 2) supine blood pressure, 3) pulse rate and regularity, 4) respiration, 5) temperature, 6) height, 7) weight (May be measured and recorded by ancillary staff) • General appearance of patient (eg, development, nutrition, body habitus, deformities, attention to grooming)
Head and Face	<ul style="list-style-type: none"> • Palpation and/or percussion of face with notation of presence or absence of sinus tenderness
Eyes	<ul style="list-style-type: none"> • Inspection of conjunctivae and lids
Ears, Nose, Mouth and Throat	<ul style="list-style-type: none"> • Otoscopic examination of external auditory canals and tympanic membranes • Inspection of nasal mucosa, septum and turbinates • Inspection of teeth and gums • Examination of oropharynx (eg, oral mucosa, hard and soft palates, tongue, tonsils and posterior pharynx)
Neck	<ul style="list-style-type: none"> • Examination of neck (eg, masses, overall appearance, symmetry, tracheal position, crepitus) • Examination of thyroid (eg, enlargement, tenderness, mass)
Respiratory	<ul style="list-style-type: none"> • Assessment of respiratory effort (eg, intercostal retractions, use of accessory muscles, diaphragmatic movement) • Auscultation of lungs (eg, breath sounds, adventitious sounds, rubs)
Cardiovascular	<ul style="list-style-type: none"> • Auscultation of heart with notation of abnormal sounds and murmurs • Examination of peripheral vascular system by observation (eg, swelling, varicosities) and palpation (pulses, temperature, edema, tenderness)
Chest (Breasts)	
Gastrointestinal (Abdomen)	<ul style="list-style-type: none"> • Examination of abdomen with notation of presence of masses or tenderness • Examination of liver and spleen

Lymphatic	<ul style="list-style-type: none"> • Palpation of lymph nodes in neck, axillae, groin, and/or other location
Musculoskeletal	
Extremities	<ul style="list-style-type: none"> • Inspection and palpation of digits and nails (eg, clubbing, cyanosis, inflammation, petechiae, ischemia, infections, nodes)
Skin	<ul style="list-style-type: none"> • Inspection and/or palpation of skin and subcutaneous tissue (eg, rashes, lesions, ulcers, ecchymoses, bruises)
Neurological/ Psychiatric	<p>Brief assessment of mental status including</p> <ul style="list-style-type: none"> • Orientation to time, place and person • Mood and affect (eg, depression, anxiety, agitation)

Content and Documentation Requirements

Level of Exam

Perform and Document:

Problem Focused

One to five elements identified by a bullet.

Expanded Problem Focused

At least six elements identified by a bullet.

Detailed

At least twelve elements identified by a bullet.

Comprehensive

Perform **all** elements identified by a bullet; document every element in each box with a shaded border and at least one element in each box with an unshaded border.

The advent and expansion of electronic medical records (“EMR”) has not only not simplified the process whereby physicians document E&M services, in many instances EMR systems have complicated matters. It is now unquestionably the case that the documentation guidelines for E&M services need to be overhauled and updated. These guidelines are 21 years old now and they are highly frustrating for certified professional coders and other health care support staff. Throughout the 20+ years that I have worked with physicians and non-physician practitioners, I’ve consistently heard the same complaint: “there are too many paperwork requirements!” I could not agree more.

In July 2018, CMS published their 1400+ page proposed rule changes for 2019. A large portion of this includes recommendations for changes in respect to E&M documentation requirements. They are calling this “Patients Over Paperwork.” Although this sounds like a positive development, in fact as the proposals stand now they are entirely counterproductive, especially when it comes to payment to physicians and other health care professionals, and particularly when it comes to specialty medical practices.

The proposal that CMS is making includes taking E&M levels 2 through 5 and condensing them into one payment, one RVU. Below is a table that CMS presented during a teleconference on August 22, 2018 showing the changes in proposed payments.

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

Level	Current Payment* (established patient)	Proposed Payment**	Level	Current Payment* (new patient)	Proposed Payment**
1	\$22	\$93	1	\$45	\$135
2	\$45		2	\$76	
3	\$74		3	\$110	
4	\$109		4	\$167	
5	\$148		5	\$211	

*Current Payment for CY 2018

**Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate

As you can see, the difference between a level 5 established patient and the proposed rate is **-\$55** and **-\$76** for new patients. Specialty providers who deal with high acuity and high risk patients such as oncology, rheumatology, neurology, nephrology, and cardiology, etc., and who typically bill on the higher end of the scale because of their patient population, will see a tremendous hit in reimbursement regardless of whether they are hospital employed or private practice. Let's do some math to see what the potential impact could be.

20 Patients/day	Current Rates	Proposed Rates	Difference
99214 (13)	\$1417	\$1209	-\$208
99215 (7)	\$1036	\$651	-\$385

This example shows an average daily revenue loss of **-\$593.00**. If this provider sees patients 251 days out of the year, this would equal an astonishing total annual loss of **-\$148,843.00** for just one provider. When you think about the number of providers throughout the United States, these numbers will increase exponentially.

The big question then becomes, "how do we fix this?" Honestly, it's really simple actually. Let's think about what elements of an encounter are truly important for clinicians. Is it the history? The exam? Or, is it the medical decision making where the provider reviews the number of diagnoses and the level of acuity and asks themselves: do they need to order any follow up testing or consultations with other providers? what type of treatment is needed? etc.

Clearly, the medical decision making is the "meat" of the note. The history and exam are simply the provider's investigation of the problem and should be pertinent to the patient's complaint. *The medical decision-making is where the provider's clinical expertise is utilized. This should be the driving factor determining a level of E&M service.*

An alternative to condensing the E & M levels is to change the documentation requirements for history and exam, with the effect that *the medical decision-making would drive the level of service*. For example, it could be reasonable to expect a provider to document an expanded problem-focused history and exam with the medical decision-making determining the level. This would allow for all five levels to be maintained without changing any reimbursements. *This would also allow for ALL E&M documentation requirements to be changed/updated rather than just those pertaining to outpatient clinic visits.*

Over the past few years CMS has excluded payments for consultations. They have changed the teaching physician guidelines to now allow for student documentation, and now they are trying to get rid of three levels of services to patients. Is this just another step forward for CMS to get rid of E&M codes altogether?

I cannot possibly be the only person who can see how easy it could be to change the guidelines without affecting payment, while still helping providers decrease the administrative burden of documentation.

Other concerns to think about with this proposed rule include: the legal implications of decreased provider documentation, patient quality and safety concerns, and increased complexity and confusion with the addition of the “add on” codes that CMS proposes to use in support of time spent and medical necessity. Not to mention the productivity and quality of coding when determining and understanding the differences in documentation requirements should commercial insurers not follow suit with these changes.

CMS has always stated that every patient must be treated and billed the same regardless of insurance payer. These changes could force the billing practices to be the exact opposite and require medical coders to bill for the sole purpose of each insurance payer’s requirements. Under the current CMS proposals as they stand, not only is there a risk that large numbers of physicians would throw up their hands and either stop taking Medicare patients or flat out leave the profession, but there’s a risk that professional medical coders would throw up their hands as well!

My recommendation to CMS: can we start this discussion over? And this time, please include the medical professional associations at the table along with some qualified coding professionals! Changes are needed ... but let’s please do it the right way and with due process.

Resources:

CMS 2019 Proposed Rule: <https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf>

1995 E&M Documentation Guidelines: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf>

1997 E&M Documentation Guidelines: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf>

CMS’ E&M Provider Education: <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/eval-mgmt-serv-guide-ICN006764.pdf>