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CMS' Proposed Change to Reimbursement for the Office/Outpatient Visit Code Sets in 2019 Has Gotten the Attention of Providers Across Specialties

Revised payment rates introduced in the Proposed 2019 Medicare Physician Fee Schedule would transform the payment landscape for evaluation and management (E/M) services rendered millions of times each year as CMS seeks to level reimbursement for these services. If finalized, New Patient Office/Outpatient encounters reported with 99202 – 99205 will be reimbursed at $135 and code set 99212 – 99215 for Established Patients will be paid at $93.

According to the Proposed Rule, CMS states that these CPT codes and their current payment rates "no longer appropriately reflect the complete range of services and resource costs associated with furnishing E/M services to all patients across the different physician specialties." To standardize the pricing, CMS would simply apply the same relative value units to the level 2 – 5 codes.

Let's look at how this would play-out against the current Medicare national payment rates in the non-facility setting:

Proposed CMS Payment Rates for Office/Outpatient Encounters in 2019

Type of Encounter	E/M Code	National Non-Facility Rate 2018	Proposed Revised Rate
New Patient	99201	$45	$44
New Patient	99202	$76	$135
New Patient	99203	$110	$135
New Patient	99204	$167	$135
New Patient	99205	$211	$135
Established Patient	99211	$22	$24
Established Patient	99212	$45	$93
Established Patient	99213	$74	$93
Established Patient	99214	$109	$93
Established Patient	99215	$148	$93

Clearly the individual impact of this change would be dependent on a provider's E/M billing profile but according to the final rule, "minimal change to overall payment" would expect to be seen for the majority of specialties. The pushback from clinicians, however, would indicate that many believe otherwise. In fact many specialties that CMS forecasts would set to gain from the change, such as Dermatology, have also opposed it.

In its August 2018 letter to CMS the AMA spoke on behalf of the 150 medical organizations that co-signed, stating their opposition to the proposed rule because it "could hurt physicians and other health care professionals in specialties that treat the sickest patients, as well as those who provide comprehensive primary care, ultimately jeopardizing patients' access to care."

Information provided by APS Medical Billing, September 2018

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As part of its proposal, CMS also addresses the long-running contention among providers that the amount of documentation required to support the higher-level E/M codes is an administrative burden that takes away from patient care. According to current documentation guidelines the extent of history-taking, examination and medical decision-making rendered (and documented) is be driven by the severity of the patient. Thus, the more complex a patient, the more bullet points of data would be expected in the visit notes.

The proposed rule would offer clinicians unprecedented flexibility in documenting their patient encounters, such as allowing them to focus more on the elements of medical decision making or time spent rendering the service rather than the historical 3 key components. Additionally, providers would only have to document to a level 2 E/M code even if the service rendered equated to a level 3, 4 or 5.

While the loosening of the rules is certainly tempting to providers who have worked for years with the 1995 and 1997 Documentation Guidelines, there is valid concern that unless the revised guidelines are adopted by the AMA's CPT, providers could face significant risk of audit liability when it comes to the commercial carriers who still work from the traditional documentation policies.

This issue is not is not expected to be finalized until November, after CMS has reviewed and considered the feedback received from the provider community. APS will continue to post relevant updates as they occur.