Pain Management Coding Alert

2019 MPFS: Get Ready in Case E/M Changes Go Through for 2019 Fee Schedule

Here's how these new CMS-proposed rules might affect your practice.

Evaluation and management (E/M) services have been relatively safe from payment reduction via the Medicare Physician Fee Schedule (MPFS) for the past few years.

Party's over? In 2019, however, E/M payments might suffer a massive letdown. At the very least, you will need to prepare for some crucial CMS revisions to how E/M services are documented, billed, and paid - which could have a profound impact on your practice's bottom line and/or workflow.

Check out some crucial points from the MPFS and how they might affect your E/M coding - and your payments for these services.

Here's How Proposal Links to E/M Pay

CMS released its proposed Medicare Physician Fee Schedule (MPFS) for 2019 on July 12, and it includes what the agency is calling "historic" E/M documentation changes to the outpatient office visit codes (99201 [Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making …] through 99215 [Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive history; A comprehensive examination; Medical decision making of high complexity …]). Those changes include the following:

- Use medical decision-making or time for outpatient E/M versus the current guidelines.
- Give physicians the option of using time as a factor even if counseling or care coordination are part of the medical equation.
- Put re-documenting aside and let providers "focus their documentation on what has changed since the last visit or on pertinent items that have not changed, according to CMS.
- Give practitioners the option of accepting data plugged in by staff instead of timely re-entering.

All That Glitters …

If this sounds so appealing that you're wondering if there's a "catch," note that there is. CMS is proposing "new, single blended payment rates for new and established patients for office/outpatient E/M level two through five visits and a series of add-on codes to reflect resources involved in furnishing primary care and non-procedural specialty generally recognized services," the agency said in a Fact Sheet about the change. The payment levels are proposed as follows:

- 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making …) through 99215: **$93 for each of these codes**
- 99202 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making ….) through 99205 (… A comprehensive history; A comprehensive examination; Medical decision making of high complexity …): **$135 for each of these codes.**

This would mean that payments for level five codes would go down, while pay for level two codes would go up. Practices that report a lot of level five codes would be likely to lose money, but some practices would see gains, says **Cyndee**

Weston, CPC, CMC, CMRS, executive director of the American Medical Billing Association (AMBA) in Davis, Oklahoma.

Decision date in air: According to CMS, the decision on the MPFS proposals is due some time this month or next. As of press time, however, CMS had not decided.

Guidelines Might Mean New Coding Conventions

Keep in mind that if the proposal is finalized, you would have to be ready to code your charts based on new criteria. For instance, if the code level ends up being based on medical decision making (MDM) rather than the current method of history, MDM, and exam, there could be a learning curve for some practices, says **Michael Granovsky, MD, FACEP, CPC,** president of LogixHealth, a national coding and billing company based in Bedford, Massachusetts.

"MDM can be subjective - the risk table is not black and white unless you're using the intervention column, which is probably historically the least relevant," he says.

Certainly, the inclusion of a suggested E/M change in the fee schedule proposal doesn't mean that a change will actually happen. But we will know, one way or another, by the end of November.

Resource: For a closer look at the MPFS proposed rule for CY 2019, visit https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-14985.pdf.