AAHKS
AMERICAN ASSOCIATION OF HIP AND KNEE SURGEONS

EPSTEIN BECKER GREEN

MEMORANDUM

To: AAHKS **From:** Epstein Becker & Green, P.C.

Date: November 5, 2018

Re: **Summary of the CY 2019 Medicare Physician Fee Schedule Proposed Rule**

The Centers for Medicare & Medicaid Services (CMS) released the calendar year (CY) 2019 Medicare Physician Fee Schedule Final Rule on November 1, 2018. AAHKS submitted comments to the Proposed Rule in September. The following is a summary of CMS final rule regarding changes to evaluation and management (E/M) codes and other relevant policies to AAHKS members.

I. Collapsing E/M Payment Levels

In the Proposed Rule, CMS emphasized that coding, payment, and documentation requirements for E/M visits are overly burdensome and no longer aligned with the current practice of medicine. To alleviate and mitigate the burden, CMS proposed to collapse the office based and outpatient E/M payment rates, documentation requirements, and create new add-on codes to better capture the differential resources involved in furnishing certain types of E/M visits. In the Final Rule, CMS finalized following:

- ***Five payment tiers will reduce to 3 tiers.*** CMS proposed to pay a single rate for level 2 through 5 E/M visits. The Final Rule policy, based on feedback from stakeholders, is that 2021, CMS will reduce the payment for E/M office/outpatient visit levels by paying a single rate for E/M office/outpatient visit levels 2 through 4 for established and new patients. The payment rate for E/M office/outpatient visit level 5 will be maintained in an effort account for the care and needs of complex patients.

- ***Additional Add-on payments for E/M.*** CMS had proposed add-on payments to recognize additional relative resources for primary care visits and inherent visit complexity that require additional work beyond what is accounted for in the single payment rates for a new patient level 2 through level 5. In the Final Rule, CMS implements add on codes that describe additional resources inherent in visits for primary care and specific non–procedural specialized medical care. These codes are only reportable with E/M office/outpatient level 2 through 4 visits.

- ***New Codes for Podiatry Visits.*** CMS sought to replace podiatrist office/outpatient visit codes with new G-codes that more specifically identify and value their services. CMS solicited public comments on what the total time would be for payment of proposed new

podiatry G codes. In the Final Rule, CMS did not finalize the creation of separate coding and payment for podiatric E/M visits.

- ***Multiple Procedure Payment Reduction (MPPR).*** CMS proposed to reduce payments by 50% for multiple services including E/M services that are performed the same day under certain conditions. The purpose of the MPPR is to reduce payments for additional services given at about the same time as other services due to some of the same resources and time applied to multiple services. CMS identified specialties that frequently report multiple E/M on the same day, such as dermatology and podiatry that would be particularly impacted. In the Final Rule, CMS did not finalize the reduced payment when E/M office/outpatient visits are furnished on the same day as other procedures.

II. Reforming Documentation Requirements

In the Proposed Rule, CMS sought to respond to stakeholder feedback that E/M documentation guidelines are outdated with respect to the current practice of medicine, by simplifying the documentation for coding E/M visits. Following are the results from the Final Rule:

- ***Removing Redundancy in E/M Documentation.*** CMS had proposed to simplify the documentation of medical history and exam for established patients. Practitioners would only be required to focus on documentation that has changed since the last visit or on pertinent items that have not changed. Practitioners would not need to re-record elements or parts where there is evidence that the practitioner reviewed and updated the previous information.

  CMS finalized this policy as proposed for 2019 to simplify the documentation of history and exam for established patients for E/M office/outpatient visits. As such, when relevant information is already included in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed.

- ***Choices in Documentation: Medical Decisions-Making (MDM), Time or Current Framework***. CMS had proposed to allow practitioners to choose, as an alternative to the current framework, either MDM or time as a basis to determine the appropriate level of an E/M visit, based on which factors matter the most to their clinical practice. As such, practitioners could use MDM, time or could continue the current framework to document an E/M visit.

  CMS finalized its proposal, effective in 2021, to allow for flexibility in how visit levels 2 through 5 are documented, specifically a choice to use the current framework, MDM, or time. For E/M office/outpatient level 2 through 4 visits, beginning in 2021, CMS will apply a minimum supporting documentation standard associated with level 2 visits when practitioners use the current framework or MDM to document the visit.

III. Alleged Overvaluation of TJA Codes

In response to the formal CMS process for the public to nominate potentially misvalued CPT codes, one party submitted 7 high volume codes for review, including 27447 (TKA) and 27130 (THA). AAHKS responded to CMS by explaining that CPT codes 27130 and 27447 should not be considered potentially misvalued and do not warrant any further action because the current valuation for the codes was established after review by the RUC and CMS in 2013.

In the Final Rule, CMS addressed AAHKS comment by stating that they do not agree that the recent review of a code should preclude it from being considered as potentially misvalued, nor does it call into question the validity of the RUC process. CMS emphasized a responsibility to identify and review potentially misvalued codes, and believe there is value in consistent and routine review of high-volume services, particularly considering that a minor adjustment to the work RVU of a high-volume code may have a significant dollar impact.

CMS will add all seven codes and will review add all seven CPT codes 27130, 27447, 43239, 45385, 70450, 93000, and 93306 to the list of potentially misvalued codes and anticipates reviewing recommendations from the RUC and other stakeholders.

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