Proposed Changes to Evaluation and Management (E/M) Billing for Medicare Beneficiaries

Annually, the Centers for Medicare and Medicaid Services (CMS) updates the Medicare fee schedule. In this year's proposed update for the 2019 Medicare fee schedule, CMS proposes changes regarding how evaluation and management (E/M) services would be documented and billed for Medicare beneficiaries. CMS believes that these changes will reduce the burden of excess documentation, allow clinicians to spend more time with their patients and focus on documenting the most important parts of a visit. In an effort to explain changes in the proposal, we have provided you with answers to the most frequently asked questions below.

It is important to note that this is a proposed rule and nothing has been made final. AANP will be submitting comments to CMS directly. As this process unfolds, these proposals may be changed or not adopted at all prior to finalization. The proposals can be found on pages 35832-35848 of the proposed rule. We encourage you to communicate with AANP prior to the September 10, 2018 comment period deadline at regulations@aanp.org.

Frequently Asked Questions:

Q. How would these proposed changes impact NP reimbursement?

A. AANP is still evaluating the impact that these changes would have on NPs. However, CMS estimates that the change in the base payment rate for NPs would be minimal, and when accounting for the new add-on codes NPs overall would see an increase in reimbursement of approximately 3% on E/M codes. It is important to keep in mind that this can vary based on practice type, setting, and patient mix, and that these numbers are based on an average of all NPs that bill Medicare.

Q. What are the applicable codes?

A. Office/outpatient visit CPT codes 99201-99205 for new patient visits and 99211-99215 for established patient visits. The proposed changes would primarily impact codes billed at levels 2 through 5.

Q. What are the proposed changes to required E/M documentation?

A. Clinicians, including NPs, could use one of three ways to document E/M Services:

1. Continue to document under current E/M guidelines; or

2. Document only using medical-decision making; or

3. Document only using time.

(For additional information on these proposed changes, see the discussion beginning on page 35835 of the proposed rule.)

Q. Would an NP have to document a patient's history to bill for a Medicare patient?

A. In this proposal, CMS would no longer require documentation of a patient's history for billing purposes of E/M visits. However, the expectation is that documenting a patient's history would continue as a part of appropriate clinical practice and other considerations such as liability. CMS is also proposing to expand the amount of medical information contained in a medical record that a practitioner could review and verify, instead of having to re-enter the information.

Q. What standard would clinicians, including NPs, need to meet using the current guidelines to bill for E/M services?

A. Codes 99202-99205 and 99212-99215 could be billed if an NP met the documentation standard for a level 2 E/M visit.

Q. Will there be new billing codes?

A. CMS is proposing to retain the current codes to simplify billing. However, there would only be one reimbursement rate for new patient visit codes 99202-99205 and one rate for established patient visit codes 99212-99215.

Q. What are the new payment rates?

A. Under the new methodology, a clinician would be paid $135 for a new patient visit (codes 99202-99205) and $93 for an established patient visit (codes 99212-99215). These rates are based solely on the fee schedule, and do not account for the 85% of the fee schedule rate that NPs are currently reimbursed under Medicare.

Q. Will clinicians, including NPs, be reimbursed less for complicated patient visits?

A. Possibly, while CMS is reducing the base payment rate for level 4 and 5 visits, they are also proposing new add on-codes that would increase reimbursement rates. Code GPC1X would be available for established patient visits that include primary care services; code GCG0X would apply to certain specialty visits; and code GPRO1 for prolonged patient visits.

As an example, CMS states that a clinician billing a level 4 established patient visit (99214) with the primary care add-on code (GPC1X) would be paid approximately $165 for the visit, which is an increase over the current rate. (Additional details on these codes can be found on pages 35841-35844 of the proposed rule.)

Q. When would these proposed changes take place?

A. CMS proposes to implement these changes on January 1, 2019. However, CMS is evaluating whether this would be feasible.

CMS Also Proposes to:

1. **Eliminate the extra documentation requirements for E/M visits furnished in the home (CPT codes 99341-99350)**

   Current Medicare billing requirements for E/M home visits state that a medical record must demonstrate the medical necessity of a home visit instead of an office or outpatient visit. CMS is proposing to remove the requirement that the medical record document the medical necessity of the home visit versus an office visit.

2. **Eliminate Prohibition on Billing Same-Day Visits by Practitioners of the Same Group and Specialty**

   Currently Medicare will not pay for two E/M visits on the same day by two practitioners of the same specialty from the same group practice, unless they can document that the visits were for unrelated problems that could not be addressed during the same encounter. CMS is soliciting comment on removing this requirement. This is an issue for NPs because under Medicare all NPs have the same "specialty" code, resulting in claim denials when two NPs in the same practice see a patient on the same day, even if the NPs are in different specialties.