Proposed Rule: CMS Proposes Major Changes to E/M Documentation Requirements and Payment

Every year, the Centers for Medicare & Medicaid Services (CMS) proposes regulations that impact the reimbursement of physicians. On July 12, 2018, CMS issued a proposed rule updating payment policies and rates for physicians paid under the Medicare Physician Fee Schedule (MPFS) in 2019. The proposed rule illustrates the importance of AAN’s regulatory advocacy efforts on behalf of neurologists and their patients. The AAN will submit comments on the proposed regulation.

E/M Updates
In the proposed rule, CMS simplifies documentation requirements for E/M office visits, which are outdated and the source of significant administrative burden for physicians. The proposal also recognizes the additional complexity of patients seen by neurologists and the need to improve payment accuracy. The agency proposes a new payment structure for E/M services that collapses the level 2 through level 5 office codes into a single payment rate and creates an add-on code to reflect the additional visit complexity inherent to E/M associated with neurology, as well as a new add-on code for prolonged E/M services, and coverage of interprofessional telephone or internet consults.

With the new proposal, practitioners will have greater flexibility in choosing how to document E/M office visits: medical decision-making, time (regardless of whether counseling or care coordination dominate the visit), or continue with the current framework. It also expands current options regarding the documentation of history and exam, allowing practitioners to focus on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information. CMS wants to allow practitioners to review and verify certain information in the medical record that is entered by ancillary staff or the patient, rather than re-entering the information. The proposal should allow practitioners more flexibility to use clinical judgment in documentation, so focus is placed on what is clinically relevant and medically necessary for the patient.

For most neurologists, E/M represents the majority of service provided, and advocating for better cognitive reimbursement has been an Academy priority for many years. This proposal represents a dramatic shift in practice, providing needed administrative relief for overburdened neurologists. To fully understand the financial impact of the proposal, the AAN is conducting a detailed analysis and will keep members posted. We will post information about new payment rates on the AAN’s Medicare Fee-for-Service page.

Proposed Coding Changes
As part of an ongoing review of potentially misvalued services, a handful of neurology codes were reviewed by the AMA Relative Value Scale Update Committee (RUC) for 2019. CMS further reduced values proposed by the RUC for analysis/programming of implanted cranial and brain neurostimulators and home sleep apnea testing services. The AAN will provide support for the RUC-recommended values as part of the comment process.
Acute Stroke Telehealth Reimbursement

Thanks to AAN advocacy efforts, Congress recently removed the restrictions on the geographic locations and the types of originating sites where acute stroke telehealth services can be furnished. CMS seeks to implement this law by proposing a new modifier that would be used to identify acute stroke telehealth services. The practitioner and, as appropriate, the originating site, would add this modifier when clinically appropriate to the HCPCS code when billing for an acute stroke telehealth service or an originating site facility fee, respectively. Practitioners would be responsible for assessing whether it would be clinically appropriate to use this modifier with codes from the Medicare telehealth list. By billing with this modifier, practitioners would be indicating that the codes billed were used to furnish telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke. CMS believes that the adoption of a service level modifier is the least administratively burdensome means of implementing this provision for practitioners, while also allowing CMS to easily track and analyze utilization of these services.

Appropriate Use Criteria (AUC) for Advanced Diagnostic Imaging Changes to be Implemented in 2020

CMS is proposing a revision to the significant hardship criteria in the AUC program. The agency will include: 1) insufficient internet access; 2) electronic health record (EHR) or clinical decision support mechanism (CDSM) vendor issues; or 3) extreme and uncontrollable circumstances. CMS is additionally proposing to add independent diagnostic testing facilities to the definition of applicable setting under this program. CMS is also proposing to allow AUC consultations, when not personally performed by the ordering professional, to be performed by auxiliary personnel. This allows the ordering professional to exercise their own discretion to delegate the performance of this consultation. CMS is also soliciting comments on the data elements and thresholds that CMS should consider when identifying outliers.

Part B Drugs Proposal

According to the proposal, physician-administered drugs in Medicare Part B would be paid for at the wholesale acquisition cost plus 3 percent for 2019. The wholesale acquisition cost is an estimate of the manufacturer's list price for a drug to wholesalers or direct purchasers, but does not include discounts or rebates. Currently, new drugs are reimbursed at the wholesale acquisition cost plus 6 percent. This change would only be for the first three months a drug is on the market. After that date, when there is average sales price data, Part B drugs would be paid for according to the average sales price plus 6 percent. The Trump administration first floated the change in its fiscal 2019 budget proposal released in February.

Quality Payment Program Updates

This is the first year CMS included updates to the Quality Payment Program (QPP) in the Proposed Fee Schedule. For 2019, CMS continues to ramp up the Merit-based Incentive Payment System (MIPS) and alternative payment model (APM) requirements. The agency created a new criterion for the low-volume threshold that is based on total number of covered professional services under the PFS. This will allow physicians who meet one but not all of the criteria to opt-in to MIPS. The MIPS category weights change slightly – Quality decreases to 45 percent of the performance year weight, Cost increases to 15 percent, Promoting Interoperability (formerly Advancing Care Information) remains at 25 percent, and...
Improvement Activities remain at 15 percent. Additionally, CMS is modifying the small and solo practitioner bonus. Instead of 5 points added toward an overall MIPS score, small and solo practitioners who submit at least one measure would receive 5 points towards their quality score.

A more detailed summary of the QPP updates can be found on AAN.com. We also encourage members to review CMS’ Quality Payment Program website. CMS offers a fact sheet that provides details on this new program. Contact macra@aan.com if you have any questions about changes proposed to the QPP.