September 7, 2018

Dear Physician Organizations:

CMS recently released a Proposed Rule for the 2019 Quality Payment Program. The Rule proposes significant changes to the current E&M system for provider payment under the Medicare fee-for-service system. The proposed changes are significant enough to call them to the attention of physician organizations.

The title of the Proposed Rule is "*Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2019; Medicare Shared Savings Program Requirements; Quality Payment Program; and Medicaid Promoting Interoperability Program*".

Proposed Rule for 2019 Quality Payment Program

There is a comment period during which CMS will accept public comment from organizations and/or individuals, regarding the Proposed Rule. Should your organization or your members wish to submit comments, the most efficient means is electronically. Please go to https://regulations.gov. Follow the "Submit a comment." instructions. The comment period ends at 5:00 PM EDT on September 10, 2018.

The following is a general summary of provider payment under the Proposed Rule. This a high-level overview and will not provide a complete understanding of the changes to be implemented in 2019. Each physician organization should conduct its own review of the Proposed Rule to determine whether or not, and how to, inform its provider members about these proposed changes.

The current five levels for outpatient E&M coding, 99201-99205/99211-99215, will be compressed to Levels 1 and 2.

Level 1 replaces 99201 and 99211. Level 2 replaces 99202-99205 and 99212-99215. All Level 2 office visits will be paid the same amount.

- As an example, Level 1 visits for established patients (Current 99211) will be paid at $24/visit (Current payment $22/visit).
- Level 2 visits for established patients (Current 99212-99215) will be paid at $93/visit (Current range $45-$148/visit).

The predicted impact on annual Medicare Part B reimbursement varies by specialty. CMS estimates the range of impact to be +/- 4%. More speculative estimates predict a range between +18% to -20%.

Billing for office visits can be done based on medical decision-making complexity, time, or traditional E&M coding. Using time, alone, for submitting billing of a Level 2 visit for an established patient requires 31 minutes, or more, of face-to-face time.

Documentation for Level 2 office visits/reimbursement will only require the amount of documentation currently required for 99202 or 99212 office visits.

There will be G codes for billing and supplemental reimbursement for additional resources or time required for more complex encounters.

CMS recognizes that certain specialties provide complex care that results in billing predominantly at 99214 and 99215 levels. There will be G codes for billing and supplemental reimbursement for these specific specialties.

CMS will reimburse for same-day visits in the same specialty or same TIN group.

There will be no requirement for documenting the medical necessity for home visits.

CMS will decrease, by 50%, reimbursement for the least expensive procedure done by the same provider or same-TIN group when an E&M code is also billed on the same day.

CMS will develop billing codes and reimburse for “virtual check-ins.” These are meant to be non-face-to-face encounters, initiated by a patient, via synchronous telehealth or communication technology. Reimbursement will be at rates lower than Levels 1 or 2 office visits and patient copayments will be required.

CMS’ “Patients Over Paperwork” initiative, which incorporates many of the elements above, is estimated to save fifty-one (51) hours of administrative burden per calendar year for a provider if 40% of their patients are in Medicare. That works out to approximately twelve minutes per day. If the estimate is simple math, then a provider with 20% of patients in Medicare would save six minutes per day.

The above information is not intended to be a complete or exhaustive description of the changes in Medicare Part B payment reform included in the Proposed Rule. Each physician organization should consider the potential impacts the Proposed Rule might have on provider reimbursement, possible changes in provider practice patterns, patient access to complex care, patient satisfaction, provider satisfaction, and mitigation of administrative burdens before deciding whether or not to provide further information to its provider membership and whether or not it would be appropriate to submit comments, or solicit individual provider comments, to CMS.

Sincerely,

Roger T. Kimura, MD

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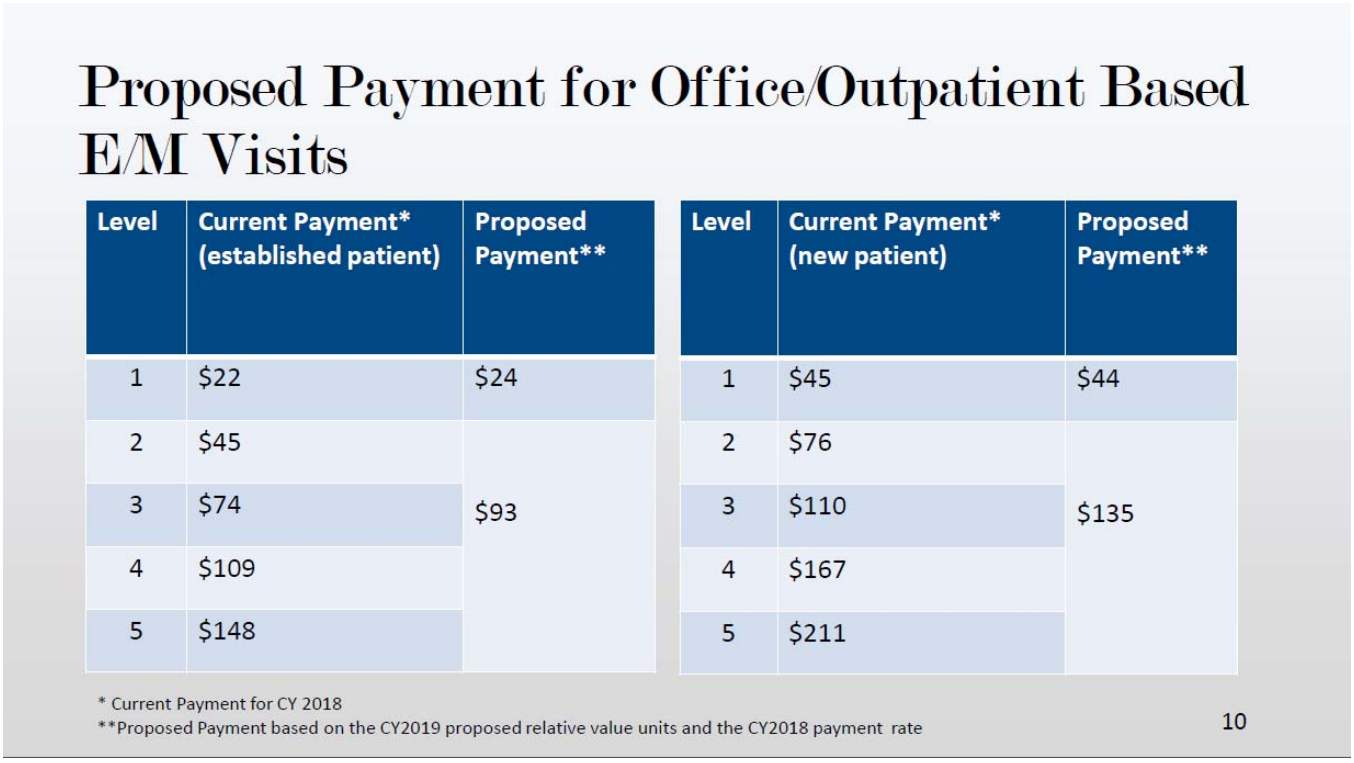
Medicare Programs Coordinator, PMAG

CMS 2019 Medicare Physician Fee Schedule Proposed Rule



Proposed Payment for Office/Outpatient Based E/M Visits

Level	Current Payment* (established patient)	Proposed Payment**
1	$22	$24
2	$45	$93
3	$74	
4	$109	
5	$148	

Level	Current Payment* (new patient)	Proposed Payment**
1	$45	$44
2	$76	$135
3	$110	
4	$167	
5	$211	

* Current Payment for CY 2018
**Proposed Payment based on the CY2019 proposed relative value units and the CY2018 payment rate

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Source: https://www.cms.gov/About-CMS/Story-Page/2019-Medicare-PFS-proposed-rule-slides.pdf