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CMS Proposals: Say Bye to Direct Supervision, Hello to Separate E/M Payments, Prior Auth

By Nina Youngstrom

In a stunning reversal, CMS plans to drop the direct physician supervision requirement for outpatient therapeutic services performed at hospitals and critical access hospitals and instead require general supervision — and do the same for some other services, including remote patient monitoring, according to the proposed 2020 Outpatient Prospective Payment System (OPPS) and Medicare Physician Fee Schedule (MPFS) regulations announced July 29. That's not the only turnabout in the regulations: CMS said it won't move forward with plans to pay one rate for three levels of evaluation and management (E/M) services, while keeping a promise to relax documentation requirements. The regulations also would bring prior authorization to a handful of procedures and more site neutrality, as CMS approves total knee replacement in ambulatory surgery centers. And hospitals are faced with an expansion of price transparency requirements that attorneys are dubious about (see story, below).

The relaxation of physician supervision requirements, which appears in different forms in both regulations, came out of left field. "What I thought was really unexpected and a good thing that CMS did is the change to supervision of hospital outpatient and critical access hospital services," says Valerie Rinkle, president of Valorize Consulting. "It's a little bit of back to the future with a cherry on top." Before 2010, CMS assumed that as long as physicians were around the hospitals, they provided for the safety of patients. But partly fueled by concerns about lack of oversight in off-campus provider-based departments, CMS created a stricter standard with direct supervision, she says, although critical access hospitals (CAHs) were repeatedly given a pass. Now it proposes to drop direct supervision, and apply general supervision to all outpatient therapeutic hospital services, whether provided at CAHs or on or off campus.

The relaxation of supervision requirements should put an end to overpayment refunds and False Claims Act cases based on the failure of physicians to directly supervise. But Rinkle worries about a possible ulterior motive. Will CMS use the relaxed physician supervision level to "continue the march toward site neutrality for certain services?" Her reasoning: Hospitals have pointed to direct supervision as a driver of higher costs in outpatient departments compared to freestanding clinics.

There was also good news for providers on E/M services and documentation. CMS proposed to drop its plan to pay physicians the same amount for CPT code levels two, three and four for office/outpatient visits, which was announced in the 2019 MPFS, although delayed until 2021 ("CMS Finalizes M.D. Payment Changes, With Delay And Level Five; Documentation Is Eased," *RMC* 27, no. 39). CMS would continue to pay separately for all E/M levels of service, which also would have different values to better capture their work relative value units (RVUs). CMS is proposing to adopt work RVUs for office/outpatient E/M codes and the new prolonged services add-on code recommended by the RVS Update Committee of the American Medical Association (see box). CMS also plans to ditch the lowest level CPT code, 99201, for new patients.

'This Is Big for Doctors'

Physicians will still have more flexibility in the way they document to support their levels of service. In addition

to the 1995 and 1997 Medicare documentation guidelines, physicians have the option of documenting their E/M level of service according to the medical decision making (without exam and history) or the time spent with the patient. CMS added to the documentation menu in 2019, but the changes don't take effect until 2021.

"Almost every proposal talks about reducing the burden on providers," says attorney Richelle Marting, with the Forbes Law Group in Overland Park, Kansas. Allowing time to drive the level of service "is great for everybody. It's very simple." Physicians won't have to spend more than 50% of their time counseling patients or coordinating their care when they choose time to select the level of service. "This is big for doctors," says Ronald Hirsch, M.D., vice president of R1 RCM, who spoke about the proposed regulations at the National Physician Advisor and Utilization Review Boot Camp in Washington, D.C., on July 29. "The total time they spend includes all the time they spend during the day preparing for the visit, during the visit and after the visit. If doctors review 600 pages of medical records before the encounter and make calls, they can count it all."

Other documentation requirements are relaxed in the 2020 proposed MPFS regulation. Physicians wouldn't have to document services that are already documented by members of the medical team. "We propose to establish a general principle to allow the physician, the PA, or the APRN who furnishes and bills for their professional services to review and verify, rather than re-document, information included in the medical record by physicians, residents, nurses, students or other members of the medical team," CMS said.

Physicians would be good to go as long as they review and sign the documentation. "You can see this as a progression" from a corner turned by CMS in February 2018, when it announced that all medical-student documentation counts for E/M billing, says attorney Ed Gaines, an executive with Zotec Partners in Greensboro, North Carolina. As a result of that change, unveiled in Medicare Transmittal 3971, teaching hospitals can charge Medicare for E/M services performed by teaching physicians when medical students document the exam, medical decision making and other parts of the patient encounter ("In Surprise Move, CMS OKs Medical Student Documentation for E/M Billing," *RMC* 27, no. 6).

Now, in the 2020 proposed MPFS, CMS is swinging open the same door wider, Gaines says. It follows because "hospital-based clinicians practice now in teams," he says. From a clinical perspective, it doesn't make sense for the physician to document again what was already documented by a member of the same care team, as long as the physician takes responsibility for reviewing and verifying the history, physical and medical decision making, Gaines says. This will be particularly helpful for rural hospitals, which may be largely staffed by advanced practice providers and under a lot of financial strain, especially in states that haven't expanded Medicaid, Gaines says.