

Report on Medicare Compliance Volume 27, Number 39. November 05, 2018 CMS Finalizes M.D. Payment Changes, With Delay And Level Five; Documentation Is Eased

By Nina Youngstrom

Medicare payments for outpatient/office visits and related documentation requirements are getting a makeover, but not until 2021, according to the final 2019 Medicare Physician Fee Schedule regulation announced Nov. 1. CMS modified its controversial proposed regulation, which would have paid physicians the same for CPT code levels two through five (RMC 7/16/18, p. 1). Instead, there will be three payment levels for new and established patients, with a blended payment for levels two through four and separate payments for levels one and five. Plenty of other changes take effect Jan. 1, including relaxed documentation standards in other areas and separate payments for virtual check-ins with physicians.

Because the payment changes are delayed, physicians also have to wait two years for new documentation options that CMS cooked up in the proposed regulation. When 2021 rolls around, physicians may stick with the 1995 and 1997 Medicare documentation guidelines or support their evaluation and management (E/M) services with medical decision-making only—forget the exam and history—or the time they spend with patients, and they only have to document to E/M level two for payment and medical review purposes (unless they bill for level five CPT codes). All these documentation methods will be on the menu.

The proposed regulation set forth a blended payment rate for new and established office/outpatient E/M visit levels two through five. CMS acknowledged that “most commenters opposed this proposal” because of “the potential negative implications of the proposal for patients with the most complex needs and the clinicians who serve them,” even though there’s widespread agreement the E/M coding structure is outdated. In response to comments, CMS is “finalizing for 2021, a single payment rate for levels 2 through 4 E/M office/outpatient visits (one rate for new, and one for established patients) and maintaining separate payment rates for new and established patients for level 5 E/M office/outpatient visits to account for the most complex patients and visits.” CMS noted level four is the most commonly reported code, and it will “monitor utilization of these services.”

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