What's in store for ObGyn reimbursement in the EHR age and beyond

ACOG intends to retain the physician lead in how ObGyns get paid for their work

Donna Tyler, and Barbara Levy, MD

In an effort to reduce burden on physicians and qualified health care professionals, the Centers for Medicare and Medicaid Services (CMS) has made changes to Evaluation and Management (E/M) documentation requirements and payment policies. Get ready for fairly extensive changes planned for CY 2021. Here we outline already-implemented and future changes and describe the commitment of the American College of Obstetricians and Gynecologists (ACOG) to ObGyn payment in its collaborations with CMS and the American Medical Association (AMA).

ILLUSTRATION: PAUL ZWOLAK FOR OBG MANAGEMENT

IN THIS ARTICLE

E/M services: CMS reduced documentation

Effective January 2019, the CMS made changes to the documentation requirements for E/M services to provide some common-sense relief for physicians facing excessive documentation requirements in their practices. Most physicians agree that modern medical practice, with the use of electronic health records (EHRs), is different now than in the mid-1990s, when the current E/M structures were developed and implemented. Streamlining documentation requirements reduces paperwork burden and some of the time-consuming duplicative work involved in medical practice today.

For instance, when relevant information is already contained in the medical record, it is not necessary to re-document a full medical history. Physicians will now be able to focus their documentation on the interval since the previous visit. Physicians should still review prior data, update as necessary, and indicate in the medical record that they have done so.

Also, for E/M office and outpatient visits for both new and established patients, physicians are no longer required to re-document information that has already been entered in the patient's record by practice staff or by the patient. If the patient's chief complaint and history already has been entered by ancillary staff or the beneficiary, the physician should simply indicate in the medical record that the information has been reviewed and verified.

For E/M visits furnished by teaching physicians, CMS has removed the requirement for potentially duplicative notations that

CONTINUED ON PAGE 33

Ms. Tyler is Director of Coding, American College of Obstetricians and Gynecologists (ACOG), Washington, DC.

Dr. Levy is Vice President for Health Policy at ACOG.

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CONTINUED FROM PAGE 32

may have been made previously in the medical records by residents or other members of the medical team.

Finally, CMS eliminated the requirement to document the medical necessity of a home visit in lieu of an office visit.

Outpatient coding changes for 2021

Outpatient coding for E/M will continue in its current form for the remainder of 2019 and 2020. However, in 2021, expect substantial changes to take effect. If the CMS rule is instituted, payment for E/M office and outpatient visits will be drastically "simplified." The current CMS plan for 2021 is to collapse payment for existing E/M Levels 2 through 4 to one payment level for new patients and one payment level for established patients, with optional add-on codes. Level 5 visits will continue at a separate payment level and with continuation of current documentation requirements.

In addition to collapsing the payment in E/M Levels 2, 3, and 4, CMS also will allow flexibility in how those E/M office and outpatient visits are documented. Specifically, documentation may be based on any of the following:

- current framework (1995 or 1997 guidelines)
- medical decision making (MDM)
- time.

When using MDM or the current 1995/1997 framework to document an office visit, Medicare will only require documentation to support a Level 2 E/M outpatient visit code for history, exam, and/or MDM. When time is used as the basis for coding the visit, physicians will document the medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary.

CMS also has finalized the creation of new add-on codes that describe the additional resources inherent in visits for primary care and particular kinds of nonprocedural specialized medical care (and will not be restricted by physician specialty). These codes would only be reportable with E/M office and outpatient level 2 through 4 visits, and their use generally would not impose new documentation requirements. It is not clear which types of visits would support the use of these add-on codes at this time.

Finally, a new "extended visit" add-on code will be available for use only with E/M Level 2 through 4 visits to account for the additional resources required when spending extended time with a patient.

CMS believes these policies will allow physicians, and all who bill E/M codes, greater flexibility to exercise clinical judgment in their documentation, so that they can focus on what is clinically relevant and medically necessary for the beneficiary.

ACOG's voice in the process

ACOG strongly opposed several proposals that CMS made during the rule-making process that the agency decided not to finalize. These aspects of the proposal would have:

1. reduced payment by 50% for the least expensive procedure or visit when an E/M office or outpatient visit is furnished on the same day as a procedure by the same physician. These are separately identifiable E/M visits that normally would be reported with a modifier 25.
2. established separate coding and payment for podiatric E/M visits, or
3. standardized the allocation of practice expense relative value units (RVUs) for the codes that describe these services.

CMS has stated that they intend to engage in further discussions with the public and stakeholders to potentially further refine the policies for CY 2021.

AMA-CPT and RUC initiative

Although the AMA, ACOG, and physicians in general applauded the CMS initiative to reduce the administrative and documentation burden on providers, there was concern about the unintended consequences of the payment changes that are currently scheduled to take effect in 2021. To address these concerns, the AMA convened a work group of physician ex-

FAST TRACK

Payment for E/M outpatient and office visits will be drastically simplified in 2021, with E/M Levels 2 through 4 collapsing payment to one level for new patients and one level for established patients, with add-on codes optional

Summary of CPT Editorial Panel actions for office or other outpatient services, February 2019 (Effective Date January 1, 2021)

- CPT code 99201 to be deleted
- Revision of codes 99202–99215 as follows:
- removing history and examination as key components
  - (A) for selecting the level of service but requiring a medically appropriate history and or examination be performed in order to report codes 99202–99215
  - (B) making the basis for code selection on either the level of medical decision making (MDM) performed or the total time spent performing the service on the day of the encounter
  - (C) changing the definition of the time element associated with codes 99202–99215 from *typical face-to-face time* to *total time spent on the day of the encounter* and changing the amount of time associated with each code.
- Revision of the MDM elements associated with codes 99202–99215 as follows:
  - (i) revising "Number of Diagnoses or Management Options" to "Number and Complexity of Problems Addressed";
  - (ii) revising "Amount and/or Complexity of Data to be Reviewed" to "Amount and/or Complexity of Data to be Reviewed and Analyzed"; and
  - (iii) revising "Risk of Complications and/or Morbidity or Mortality" to "Risk of Complications and/or Morbidity or Mortality of Patient Management."
- Revision of the E/M guidelines by:
  - (A) restructuring the guidelines into three sections: "Guidelines Common to All E/M Services," "Guidelines for Hospital Observation, Hospital Inpatient, Consultations, Emergency Department, Nursing Facility, Domiciliary, Rest Home or Custodial Care and Home E/M Services," and "Guidelines for Office or Other Outpatient E/M Services" to distinguish the new reporting guidelines for the Office or Other Outpatient Services codes 99202–99215
  - (B) adding new guidelines that are applicable only to Office or Other Outpatient codes (99202–99215); adding a Summary of Guideline Differences table of the differences between the sets of guidelines
  - (C) revised existing E/M guidelines to ensure there is no conflicting information between the different sets of guidelines
  - (D) adding definitions of terms associated with the elements of MDM applicable to codes 99202–99215
  - (E) adding an MDM table that is applicable to codes 99202–99215
  - (F) defining total time associated with codes 99202–99215
  - (G) adding guidelines for reporting time when more than one individual performs distinct parts of an E/M service; revision of the MDM table in the Amount and/or Complexity of Data to be Reviewed and Analyzed column:
    - (1) inserted a dash (-) after the asterisk in the asterisk definition, "* - Each unique test, order, or document may be summed if multiple," to clarify this is the meaning of the asterisk and not an asterisked item itself
    - (2) for limited amount of data to be reviewed and analyzed (codes 99203/99213), the parenthetical regarding the number of categories for which requirements must be met was revised to state, "…categories of tests and documents, or independent historian(s)" rather than "categories within tests, documents, or independent historian(s)"
    - (3) removing the word "or" after each of the bulleted items for limited, moderate (codes 99202/99214), and high (99205/99215) amount and/or complexity of data to be reviewed and analyzed.

perts who are knowledgeable in the *Current Procedural Terminology* (CPT) code development and valuation processes. The charge to the E/M work group is to collaborate across the provider, payer, and coding communities to establish or revise the coding structure and guidelines for outpatient E/M services. The members formed a multispecialty work group representing primary care and surgical specialties and have experience in developing, defining, and valuing codes.

Dr. Barbara Levy, ACOG's Vice President of Health Policy, co-chaired this expert panel with geriatrician Dr. Peter Hollmann to develop comprehensive consensus-led changes to revise and modernize E/M codes. The work group followed 4 guiding principles to inform their E/M work:

1. to decrease the administrative burden of documentation and coding
2. to decrease the need for audits
3. to decrease unnecessary and redundant

documentation in the medical record that is not needed for patient care

4. to ensure that payment for E/M services is resource based. There is no direct goal for payment redistribution among specialties.

A primary concern expressed by physicians about the CMS proposal was that the collapse of payment for E/M visit across levels 2–4 might lead to a lack of appropriate care for more complex patients since the CMS rule does not provide payment based on the resources required to perform the work of the visit. No one believes that the work needed to care for someone with a sore throat or pink eye is equivalent to the work involved in diagnosing and managing depression, for example.

Beginning in August 2018, the work group met regularly to build consensus. The work group worked at an accelerated pace to develop and value codes that better fit the current medical workflows and meet patient needs.

The work group submitted a code change proposal for E/M codes to the CPT Editorial Panel for consideration during the February 2019 meeting. The next step was the code valuation process through the AMA/Specialty Society RVS Update Committee (RUC) process.

CMS has stated that the 2-year delay to 2021 in implementation of their original proposed changes is to allow time for the E/M code change proposals to move through the development and valuation process and subsequent review by the agency. To date, commercial payers and coders have been supportive of the AMA E/M work group proposals. Dr. Levy, Dr. Hollmann, and AMA staff are meeting with CMS and Department of Health and Human Services staff to provide clarity as they review the CPT proposals. ACOG supports the changes, which would simplify documentation for outpatient E/M codes while retaining differential payments. CMS is closely following the progress of the code changes through the CPT process and RUC code valuation process. We await further rulemaking by CMS in defining and valuing this important code set.

ACOG is at the helm, with a watchful eye

This is a challenging undertaking because E/M codes are used across specialties for office visits and outpatient care. The potential for unintended consequences for all services that include E/M, such as the global obstetrical services or 90-day global surgical services, is substantial. ACOG is intimately involved in this undertaking, watching the developments carefully to ensure that the interests of ObGyns and their patients are protected. ●