THE CODING NETWORK
LIMITED LIABILITY COMPANY

September 7, 2018

Submitted Electronically

The Honorable Seema Verma
Administrator
Centers for Medicare and Medicaid Services
U.S. Department of Health and Human Services
Hubert H. Humphrey Bldg., Room 445-G
200 Independence Avenue, SW
Washington, DC 20201

Re: CMS Proposed Fee Schedule Changes for 2019 (CMS-1693-P)

Dear Administrator Verma,

We are writing to you on behalf of The Coding Network, LLC (TCN) in regard to the proposed changes to Evaluation & Management (E/M) visit documentation and payment as described in Part II.I.2. of the above-referenced proposed rule published by the Centers for Medicare & Medicaid Services (CMS). TCN has provided medical coding and auditing services to over one thousand providers across a broad spectrum of medical specialties throughout the country over the course of more than twenty years. While we support CMS's objective to reduce the paperwork burden for physicians by reducing the documentation requirements for certain E/M visits, TCN strongly urges CMS not to implement the current proposal of collapsing payment rates for E/M outpatient services, levels two through five, in its current form. TCN believes that an easing of E/M documentation requirements can be accomplished without having to simultaneously change the payment structure for certain E/M visits, especially in a manner that could harm the viability of many providers across many critical specialties.

TCN further submits that the magnitude of the proposed E/M changes warrants more comprehensive input from key stakeholders. TCN believes that it is crucial that CMS work in close coordination with organizations such as the American Medical Association (AMA), Medical Group Management Association (MGMA) and representatives from specialty medical societies, whose members have a vested interest in providing quality medical care and being appropriately reimbursed for their services. The breadth, complexity and weight of CMS's proposed changes to E/M visits deserves careful consideration and meaningful input from key stakeholders.

Changes to Documentation Guidelines

TCN supports CMS's initiative to simplify and streamline E/M documentation requirements but believes that the proposed changes need further refinement. Based on the present proposal from

CMS, TCN believes that the following changes to documentation requirements should be adopted in CY 2019 with clear guidance and instruction from CMS:

- Require documentation of an established patient's history to focus only on an interval history since the previous encounter. (This would be actual clarification of a concept which already exists in the 1995 and 1997 guidelines.)
- Allow ancillary staff or the patient to document patient history and eliminate the requirement for physicians to personally re-document information that has already been obtained. (Provide guidance on how physician review should be documented.)

These changes would serve to streamline documentation, reduce unnecessary note bloat, improve workflow and allow physicians more time with their patients.

However, we disagree with CMS's proposal to require that practitioners only need to meet documentation requirements currently associated with a level 2 visit. Medical records must paint the picture of the patient's presentation, assessment and plan of care. Decreasing documentation to such an extreme level may not benefit the patient or the provider whose medical note is a clinical document, billing document and legal document. Requiring the same documentation for complex visits as more simplistic visits fails to take into account that the level of documentation may need to vary depending on the type of care provided. It does not seem to be practicable to require the same documentation for a simple complaint of a urinary tract infection as a visit for a complex cardiology patient with multiple chronic conditions. Furthermore, when patients see multiple providers for care, the providers are reliant upon the thoroughness of the other providers' documentation to provide quality care. Relaxing the documentation requirements in more complex treatment scenarios such as these could adversely affect patient care.

Therefore, we recommend that CMS undertake an in-depth analysis of the existing CPT E/M code descriptors and CMS documentation guidelines in tandem with the AMA and medical specialty societies to further refine the existing documentation requirements so as to eliminate gray areas and provide further efficiencies while protecting the interests of both patients and providers. We believe the concept of five levels of service does work. However, the advent and proliferation of EMRs has had an adverse effect on the evolution of documentation processes in recent years, and there has been inconsistency in how different MACs have enforced documentation requirements. We believe it is time for an overhaul, not an elimination, of the main framework.

With the proposed retention of the reworked 1995 and 1997 guidelines, we further recommend that medical decision-making be required as one of the two key components for an established patient encounter. Currently, any two of the three key components determine the level of service. This allows higher levels of service due to bloated histories and exam. This recommendation is in concert with using medical decision-making as a major component for assignment of the appropriate E/M level.

Financial Impact

As previously stated, TCN disagrees that a reduction in E/M documentation requirements should be tied to changes in compensation for providers in the manner that CMS has proposed. By collapsing payments for levels 2 through 5, physicians may be more severely impacted financially than CMS has indicated (see "The Proposed 2019 E&M Overhaul: A Preliminary Financial Impact Analysis, https://www.racmonitor.com/the-proposed-2019-e-m-overhaul-a-preliminary-financial-impact-analysis). We encourage CMS to provide more transparency in its calculation of the financial impact on different specialties. The single blended payment rate for levels 2 through 5 negatively impacts those providers who render more 99204s, 99205s, 99214s or 99215s due to the complexity of their patients with the greatest medical needs. Therefore, there is great concern from healthcare professionals that the collapsed fee schedule would penalize providers who tend to see more complex patients, which may ultimately negatively impact the patients who require such treatment.

It's estimated that certain practices will incur substantial losses in both RVUs and Medicare payments (see "The Proposed 2019 E&M Overhaul: A Preliminary Financial Impact Analysis, https://www.racmonitor.com/the-proposed-2019-e-m-overhaul-a-preliminary-financial-impact-analysis). Ten key specialties could see a loss of 3-4% of their overall payments.

Another potential consequence of the proposed payment changes is that the overall payments to providers could increase by hundreds of millions of dollars (see https://www.racmonitor.com/the-proposed-2019-e-m-overhaul-a-preliminary-financial-impact-analysis). This raises the question of whether the proposed payment changes comply with the budget neutrality requirements of Section 1848(c)(2)(B)(ii)(II) of the Act. Given the conflicting data surrounding the effects on provider payments that would result from CMS's proposed payment changes, we think it is critical that CMS forego implementation of such changes until it has undertaken further review of the relevant data and confidently resolved such discrepancies.

E/M Multiple Procedure Payment Reduction

CMS proposes to reduce payment by 50% for the least expensive procedure or visit that the same physician or physician in the same group practice furnishes on the same day as a separately identifiable E/M visit appended with modifier 25.

TCN disagrees with this proposal and urges CMS not to adopt it. While we understand that CMS may have concerns regarding providers' use of modifier 25, TCN recommends that CMS address these concerns by publishing clarifying information as to what should be documented in the medical record to support all services instead of drastically reducing payment. In the past, several major commercial plans attempted to apply a payment reduction to visits with modifier 25 and procedures. The outcry from the physician community was strong, and we expect that CMS's current proposal will attract a similar response. Again, education of the provider community is important to resolve CMS's concerns rather than penalizing providers.

Confusion Surrounding Application of G-Codes as Add-On Payments

With regard to CMS's proposed use of new add-on codes, we believe further explanation is required as to their use and applicability. There appears to be conflicting information as to when

and by whom these complexity G-codes can be used. The Federal Register identifies specialties which can assign GCG0X. However, CMS's live presentation addressing the proposed rule seemed to suggest that other specialties can assign this code also. Clarification as to who can use these add-on codes, documentation requirements and true financial impact are greatly needed.

Postpone Implementation of Proposed E/M Changes

We note that CMS has expressly stated that it is sensitive to commenters' suggestions that a multi-year process for implementation of the proposed changes should be considered. TCN believes that more time is needed to refine the details of the proposed E/M documentation and payment changes and to test those changes before final implementation. Changes of this magnitude should not be implemented until 2020 at the earliest. As previously stated, collaboration with key stakeholders should occur prior to implementation of the proposed changes. Testing the concepts in practice environments should also occur to provide an opportunity to resolve any unintended negative consequences of the changes.

MGMA along with the AMA and many specialty medical societies stand ready to work with CMS to improve complicated coding, payment and documentation requirements for different levels of E/M services. We also urge CMS to coordinate with private payers in order to avoid material differences in how they approach documentation and coding requirements, which would serve to further overburden providers and undercut perceived improvements in documentation and coding requirements.

Unintended Consequences

TCN is concerned that notwithstanding CMS's intention to bring efficiencies to and improve upon existing documentation, coding and payment requirements, the proposed changes to E/M visits would result in a number of negative unintended consequences that could be seriously injurious to providers and patients. They are as follows:

- As previously mentioned, the proposed changes to payments for level 2 through 5 E/M visits could result in (1) financial detriment to a number of important specialties that serve patients with complex needs and (2) a dramatic increase in payments to certain specialties that may violate the budget neutrality requirements of Section 1848(c)(2)(B)(ii)(II) of the Act (see https://www.racmonitor.com/the-proposed-2019-e-m-overhaul-a-preliminary-financial-impact-analysis; and https://www.racmonitor.com/analysis-deep-thoughts-on-the-2019-proposed-e-m-changes).
- Certain providers may be less inclined to treat Medicare patients under the new payment model for fear of underpayment.
- In more complex healthcare systems, a portion of the physician's compensation is based on the physician's historical work RVU performance. Changing E/M RVUs in such a sudden and dramatic manner may disrupt carefully determined compensation arrangements between physicians and the health systems for which they work (see "Impact on Work RVUs Expected to be Far-Reaching – Including

the Revenue Cycle", https://www.racmonitor.com/impact-on-work-rvus-expected-to-be-far-reaching-including-the-revenue-cycle).

- Coding and auditing performance could undergo substantial changes if the proposal is finalized as it currently exists. Coders and auditors would have to code and audit based upon four ways to evaluate a patient visit (1995 or 1997 guidelines; time and medical necessity; medical decision-making; and minimum documentation standard of a level 2 visit).

Conclusion

TCN is supportive of CMS's effort to reduce physician paperwork by developing a documentation approach that meets the needs of the physician and the patient. We are willing to assist in providing any further comments or analysis that may be helpful to CMS. TCN's representative can be contacted at ngreen@codingnetwork.com.

Sincerely,

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