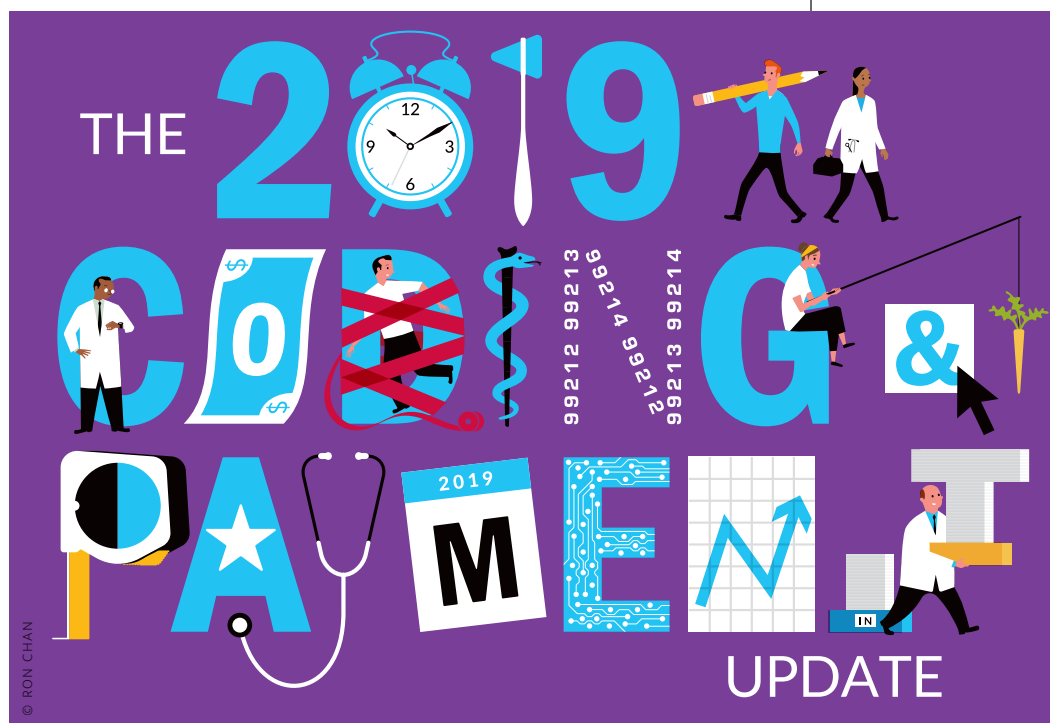


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The 2019 Medicare Documentation, Coding, and Payment Update

This year's changes include some welcome documentation relief, new codes for portal and telephone encounters, and much more.



January always ushers in changes to the Medicare program that affect physician payment and coding, but this year's update is more notable because it includes changes to the documentation requirements, a variety of coding updates, and some added flexibility in Medicare's Quality Payment Program (QPP). Here's a summary of the changes most relevant to family physicians.

CHANGES IN MEDICARE DOCUMENTATION POLICY

In 2019, the Centers for Medicare & Medicaid Services (CMS) offers physicians some documentation relief, especially as it relates to evaluation and management (E/M) coding.

CMS is simplifying the documentation of history and exam for established patients. Before 2019, the E/M documentation

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guidelines provided some limited flexibility in documenting the history of an established patient. For example, a review of systems (ROS) or a pertinent past, family, or social history (PFSH) obtained during an earlier encounter did not need to be re-recorded if the record contained evidence the physician reviewed and updated the previous information. Similarly, the ROS or PFSH could be recorded by ancillary staff or on a form completed by the patient; to

For both history and exam, physicians are only required to focus their documentation on what has changed since the last visit or on pertinent items that have not changed.

document that the physician reviewed the information, he or she simply needed to add a notation supplementing or confirming the information recorded by others.

CMS is expanding this flexibility in 2019. For both history and exam, physicians are only required to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting a defined list of required elements. Physicians do not need to re-record these elements (or parts thereof) if the record contains evidence that they reviewed and updated the previous information. Additionally, for both new and established patients, physicians

no longer must re-enter information in the medical record regarding the chief complaint and history (including the history of present illness) that either ancillary staff or the patient have already entered.

A physician could choose to re-enter or bring forward information when documenting a visit. However, this is now optional.

CMS is doing something similar for teaching physicians. Federal regulations previously required teaching physicians to personally document their participation in the medical record for E/M visits and to document the extent of their participation in the review and direction of services furnished to each Medicare beneficiary. Medicare has amended those regulations so that, with some exceptions, the notes of a resident or other member of the medical team may suffice instead, and the onus of documentation doesn't always fall on the teaching physician. (See the related Q&A in the "Coding & Documentation" department, page 30.)

Lastly, CMS has removed the requirement that the medical record must document the medical necessity of furnishing a visit in the home rather than in the office. If the encounter is medically necessary, where it occurs is immaterial.

CMS had proposed some additional, significant E/M documentation changes, such as relaxing the requirements and using a single blended payment rate for codes 99212-99215. However, after hearing many concerns from physician groups, CMS decided to revise and delay those proposals until 2021 (see https://www.aafp.org/journals/fpm/blogs/gettingpaid/entry/2019_physician_fee_schedule_final_rule.html).

KEY POINTS

- Medicare has eased physicians' documentation burden by removing the requirement that they re-enter in the medical record the chief complaint or history information that staff or patients have already entered.
- Several new codes make interprofessional consults and virtual encounters easier to bill for when they involve the care of Medicare patients.
- For physicians participating in MIPS, accountability for the cost of care has increased slightly, along with the performance threshold (i.e., the minimum number of points a physician must earn in 2019 to avoid a negative payment adjustment in 2021).

CODING CHANGES

This year's CPT and HCPCS coding changes cover a wide array of services, from chronic care management to virtual encounters. (See a brief summary in "New codes for 2019.")

Interprofessional telephone, internet, or electronic health record (EHR) consultations. Interprofessional telephone/internet consultation codes received an overhaul for 2019 along with the addition of two new codes. CPT codes 99446-99449 now allow time spent consulting via telephone

NEW CODES FOR 2019

CPT

11102 Tangential biopsy of skin (e.g., shave, scoop, saucerize, curette) single lesion.

+ 11103 Each separate/additional lesion (list separately in addition to code for primary procedure).

11104 Punch biopsy of skin (including simple closure, when performed) single lesion.

+11105 Each separate/additional lesion (list separately in addition to code for primary procedure).

11106 Incisional biopsy of skin (e.g., wedge) (including simple closure, when performed) single lesion.

+11107 Each separate/additional lesion (list separately in addition to code for primary procedure).

(Note: Skin biopsy codes 11100 and 11101 have been deleted.)

90689 Influenza virus vaccine, quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use.

99451 Interprofessional telephone/internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time.

99452 Interprofessional telephone/internet/electronic health record referral service(s) provided by a treating/requesting physician or other qualified health care professional, 30 minutes.

(Note: Current interprofessional telephone/internet consultation codes 99446-99449 have been revised to include the time required to review and analyze the EHR.)

99453 Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; set-up and patient education on use of equipment.

99454 Remote monitoring of physiologic parameter(s) (e.g., weight, blood pressure, pulse oximetry, respiratory flow rate), initial; device supply with daily recording or programmed alert transmission, each 30 days.

99457 Remote physiologic monitoring treatment management services, 20 minutes or more of clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month.

99491 Chronic care management (CCM) services, provided personally by a physician or other qualified health care professional, at least 30 minutes of physician or other qualified health care professional time, per calendar month. All other CCM requirements apply.

HCPCS

G2012 Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report E/M services, provided to an established patient, with five to 10 minutes of medical discussion. The service must not originate from a related E/M service provided within the previous seven days nor lead to an E/M service or procedure within the next 24 hours or until the soonest available appointment.

G2010 Remote evaluation of recorded video or images submitted by an established patient (e.g., store and forward), including interpretation and follow-up with the patient within 24 business hours. The service must not originate from a related E/M service provided within the previous seven days nor lead to an E/M service or procedure within the next 24 hours or until the soonest available appointment.

or internet about a patient's status to also include the time required to review and analyze the EHR. Codes 99446-99449 still require a verbal interaction with the requesting physician and include the resulting written report. New codes 99451-99452 allow reporting of the same functions without the verbal consultation requirement.

Medicare does not pay for codes 99446-99449 in the nonfacility (e.g., office) setting, but codes 99451-99452 are priced in the nonfacility setting. Check with your individual payers to verify whether the code set will be paid under their fee schedules.

Digitally stored data services/remote

physiologic monitoring. If a patient is prescribed the use of a Food and Drug Administration-approved device to monitor physiologic issues such as weight, blood pressure, or pulse oximetry, you can now use CPT codes to report the set-up and education for the device (99453), as well as the 30-day supply of the device (99454). To report the physician review, analysis, care plan, and documentation of these activities, use existing code 99091. Remember that 99091 is time-based and requires a minimum of 30 minutes. Also, note that CPT has moved code 99091 out of the "Medicine" section and reclassified it as an E/M service. Another

new option within this realm is code 99457, remote physiologic monitoring treatment management services, 20 minutes or more per month delivered by clinical staff/physician/qualified healthcare professional, which requires interactive communication regarding the service with the patient or caregiver. Medicare will allow payment for all these codes in 2019.

Chronic care management (CCM) services. Code 99490 for CCM became a payable service under Medicare in 2015. This

The higher rate for chronic care management code 99491 reflects the fact that the service is personally performed by the physician.

service is managed by a physician, but clinical staff as defined by CPT typically perform most of the CCM functions, and the service is priced accordingly. New in 2019 is CPT code 99491 for CCM services performed by a physician or other qualified health care professional, consisting of at least 30 minutes in a calendar month. The other requirements of CCM still apply.

The 2019 Medicare allowance for code 99491 is approximately \$83.97, which is higher than the allowance of \$42.17 for code 99490. The higher rate for code 99491 reflects the fact that the service is personally performed by the physician rather than clinical staff under the physician's supervision. Check with other payers for their coverage determinations and corresponding payment policy.

Skin biopsy services. CPT now provides definitions to help guide code selection for different types of skin and mucous membrane biopsies. Biopsy code 11100 and add-on code 11101 have been deleted. There are three types of biopsies for consideration: tangential, punch, and incisional. Tangential biopsies equate to shaving, scooping, saucerizing, or curetting the lesion (code 11102 for a single lesion and +11103 for each separate/additional lesion). Punch biopsies require the use of a punch tool to remove a full thickness

cylindrical skin sample (code 11104 +11105). An incisional biopsy uses a sharp blade to remove a full-thickness sample delving through the dermis into the subcutaneous tissue (code 11106 +11107). Simple closure is included in all these codes. The definition of a biopsy has not changed: obtaining a sample of the lesion for pathological review and determination.

Medicare national average allowances in the nonfacility (e.g., office) setting are as follows:

- Tangential biopsy (11102 +11103): \$100.91 and \$54.42, respectively,
- Punch biopsy (11104 +11105): \$126.86 and \$62.35, respectively,
- Incisional biopsy (11106 +11107): \$153.53 and \$73.52, respectively.

New vaccine code. Only one new vaccine code has been added for 2019:

Code 90689, Influenza virus vaccine, quadrivalent (IIV4), inactivated, adjuvanted, preservative free, 0.25mL dosage, for intramuscular use.

For payment details, consult the Medicare Average Sales Price website (<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Part-B-Drugs/McrPartBDrugAvgSalesPrice/index.html>) and check with other payers to whom you may be submitting claims for this vaccine.

Virtual encounters. Many physicians spend time delivering historically nonbillable services such as telephone and portal encounters with patients. CMS now has a billable code for these services: HCPCS code G2012, Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report E/M services, provided to an established patient, with five to 10 minutes of medical discussion. The service must not originate from a related E/M service provided within the previous seven days nor lead to an E/M service or procedure within the next 24 hours or at the soonest available appointment time.

Similar to G2012 is new code G2010, Remote evaluation of recorded video or images submitted by an established patient (e.g., store and forward), including interpretation and follow-up with the patient within 24 business hours. Again, the service must not originate from a related E/M service provided within the previous seven

days nor lead to an E/M service or procedure within the next 24 hours or until the soonest available appointment.

Note that these G-codes are created and governed by CMS and are not mandated for use by commercial payers. Some payers other than Medicare may consider them for payment, but payment is not guaranteed; therefore, practices should verify whether these codes are included in a payer’s fee schedule before delivering services.

QUALITY PAYMENT PROGRAM (QPP) CHANGES

In 2015, Congress passed the Medicare Access and CHIP Reauthorization Act (MACRA), which established the QPP and its two tracks for physician payment under Medicare: Merit-based Incentive Payment (MIPS) and Advanced Alternative Payment Models. Jan. 1, 2019, marks the first year physicians participating in MIPS will see their Medicare payments adjusted, positively or negatively, based on the 2017 QPP performance year.

The 2019 requirements. In February 2018, the Bipartisan Budget Act of 2018 (BBA) granted CMS additional flexibility in how it implements the QPP, which CMS used as it finalized policies for the 2019 QPP performance year. (See “The 2019 MIPS requirements at a glance.”)

First, the BBA provided a slower transition to full accountability for physicians for the MIPS cost performance category. Initially, MACRA required the cost category to account for 30 percent of the MIPS final score in performance year 2019. The BBA allows CMS to set the weight of the cost category between 10 percent and 30 percent during performance years 2019 to 2021 and requires a weight of 30 percent in performance year 2022. For performance year 2019, CMS has increased the weight of the cost performance category from 10 percent to 15 percent and decreased the weight of the quality category from 50 percent to 45 percent. The “promoting interoperability” category (formerly known as “advancing care information”) remains at 25 percent, and improvement activities remain at 15 percent.

Second, the BBA authorized a more gradual increase in the performance threshold, that is, the minimum number of points a physician must earn to avoid a negative

payment adjustment. MACRA required the performance threshold to be either the mean or median of the previous year’s MIPS scores by performance year 2019. The BBA allows CMS to gradually increase the threshold during performance years 2019 to 2021 and transition to the mean or median by 2022. To avoid a negative 7 percent payment adjustment in 2021 (based on performance in 2019), participants must meet or exceed the MIPS performance threshold of 30 points this year, up from 15 points in 2018. The exceptional performance threshold has increased from 70 points to 75 points.

Third, the BBA made changes to the low-volume threshold calculation, which determines whether a physician is excluded from a MIPS payment adjustment due to a low volume of beneficiaries or allowed charges. Previously, low-volume threshold determinations were made using all Medicare Part B allowed charges, including Part B medications and Part B services not paid under the Medicare physician fee

THE 2019 MIPS REQUIREMENTS AT A GLANCE

Performance year: 2019

Payment year: 2021

Performance categories:

Cost	15 percent
Quality	45 percent
Promoting interoperability	25 percent
Improvement activities	15 percent

Performance threshold (points required to avoid a negative payment adjustment): 30 points

Exceptional performance threshold: 75 points

Performance reporting periods:

Quality	One year
Cost	One year
Promoting interoperability	90 consecutive days
Improvement activities	90 consecutive days

Measures required:

Six (nine if using the CMS web interface for submission)

View a list of the different measures

you can submit data for on the QPP website:

<https://qpp.cms.gov/mips/explore-measures/quality-measures>.

schedule. The BBA removed Part B medications and any services not paid under the fee schedule from the low-volume calculation, which began with performance year 2018 (i.e., payment year 2020).

In addition, CMS has added one criterion, number of professional services, to the threshold in 2019. A physician is now below the low-volume threshold if he or she does any of the following:

Jan. 1, 2019, marks the first year physicians participating in MIPS will see their Medicare payments adjusted, positively or negatively, based on the 2017 QPP performance year.

- Has <\$90,000 in Part B allowed charges for covered professional services,
- Provides care to <200 Medicare Part B beneficiaries,
- Provides <200 covered professional services to Medicare beneficiaries.

Any eligible clinician who meets the low-volume threshold exclusion has the option to opt-in and participate in MIPS if he or she meets or exceeds one or two of the low-volume threshold criteria. These opt-in participants will be eligible for both positive and negative payment adjustments.

Lastly, the BBA changed how the MIPS payment adjustments get applied. Prior to the BBA, MIPS payment adjustments, both positive and negative, applied to all items and services under Medicare Part B (such as medications). Now, payment adjustments will only apply to covered professional services paid under the Medicare physician fee schedule.

One notable “nonchange” is the stability of the performance periods. For performance year 2019, quality and cost will continue to be measured for one year. Improvement activities and promoting interoperability require 90 consecutive days of reporting.

Bonus points. In 2019, Medicare will add six bonus points to the quality score of any eligible clinician in a small practice

(15 or fewer clinicians billing under a single tax identification number). This differs slightly from performance year 2018, when CMS added five bonus points to the MIPS final score.

Small practices will continue to receive three points for all quality measures reported, regardless of whether they meet the data completeness criteria. All other practices will receive one point for measures that do not meet data completeness.

CMS will add up to five bonus points to the final score of any size practice based on the care of complex patients. CMS calculates this score using the average hierarchical condition categories score of the patient panel and percentage of dual-eligible (having both Medicare and Medicaid) patients.

Small practice options. In addition to offering small practice bonuses, CMS is allowing small practices these options:

- Submit data for covered professional services using Medicare Part B claims (as opposed to using a registry, EHR, or the CMS web interface) for the “quality” performance category,
- Apply to receive a reweighting of the “promoting interoperability” performance category (with the 25 percent added to the quality performance category) if they have issues acquiring an EHR,
- Participate in MIPS as a virtual group,
- Receive no-cost, customized support through the Small, Underserved, and Rural Support technical assistance initiative.

BUT WAIT, THERE’S MORE

These are not all the updates within CPT, HCPCS, the Medicare Physician Fee Schedule, or the QPP. These updates reflect a high-level list of the most important changes you may want to know about as 2019 begins. For a more complete update, consult your 2019 CPT and HCPCS books as well as the American Academy of Family Physicians’ 2019 MIPS Playbook (https://www.aafp.org/content/dam/AAFP/documents/practice_management/restricted/2019-mips-playbook.pdf), a step-by-step guide to MIPS participation. **FPM**

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