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POLICY BRIEF

Streamlining Evaluation and Management Payment to Reduce Clinician Burden

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POLICY STATEMENT TITLE

- Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden—Part of the 2019 Calendar Year Physician Fee Schedule Final Rule

ORGANIZATION

- Centers for Medicare and Medicaid Services (CMS)

RELEASE DATE

- November 1, 2018

POLICY CONTEXT

Documentation in the medical record is an everyday occurrence for most clinicians. The medical record enables communication to members of the treatment team and monitoring of patient care over time. Although not a primary focus for most clinicians, the medical record also facilitates assessment of resource utilization, evaluation of health care quality, and collection of data that may be used for research purposes.

To bill for medical and surgical evaluations (Evaluation and Management [E/M] services), documentation is required that is commensurate with the care provided.[1] A number of Current Procedural Terminology (CPT) codes exist for this purpose, defined by the patient type (new versus established), the setting of service (office or outpatient setting, hospital inpatient, emergency department, nursing facility, etc), and the level of care provided. The level relates specifically to details around the presenting problem, patient history, physical examination, medical decision-making, counseling, and coordination of care.

In 1995, the Centers for Medicare and Medicaid Services (CMS) introduced documentation guidelines related to E/M services.[2] An updated version was published in 1997,[3] differing mostly in documentation requirements related to the physical examination. Criteria outlined in both versions were felt to be acceptable for billing Medicare (and subsequently, commercial payers), assuming that specific criteria were met. In most circumstances, this included the reason for the encounter, a relevant history, physical examination findings, diagnostic test results, an assessment, and a care plan.

Today, there is an ever-strengthening belief that documentation is performed largely to comply with coding requirements.[4] Time required for this can be significant, limiting the opportunity to more fully address patient needs and coordinate care. In fact, it is relatively common for clinicians to dedicate

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a large portion of their workday to documentation, with carryover after hours.[5] This alone has been a significant contributor to clinician burnout and professional dissatisfaction.[6,7]

Electronic health record systems offer a number of advantages, including the ability to surface relevant clinical information at the point of care. When documenting in the electronic health record, however, it is commonplace for templates to be used to ensure that billing requirements are met.[8] Notes generated using this approach can be lengthy, excessively comprehensive, and for the most part, hard to read.[4,9] Rather than facilitating effective communication, these notes run the risk of burying clinical impressions and recommendations, potentially undermining coordination of care.

To address these and other issues, CMS launched its *Patients Over Paperwork* initiative in 2017 with a goal of reducing administrative burdens, increasing efficiencies, and improving the beneficiary experience.[10] A principle goal was to simplify documentation requirements, leaving clinicians greater time to spend with patients and focus on things that had changed since the last visit. The program also placed increased emphasis on team-based care, sought to minimize redundant documentation, and pushed for standards driven by medical decision-making.

MAJOR FINDINGS/RECOMMENDATIONS

On November 1, 2018, as part of the 2019 Calendar Year Physician Fee Schedule Final Rule, a number of documentation, coding, and payment changes were made that aimed to reduce clinician burden and streamline E/M documentation for Medicare Fee-For-Service patients.[11]

For calendar years 2019 and 2020, many of the coding and payment structures remain unchanged. Clinicians should continue to use the 1995 or 1997 E/M documentation guidelines (from here forth referred to as the current framework) when documenting visits billed to Medicare. However, a small number of important changes to outpatient documentation began in calendar year 2019.[12] These include the following:

- A greater push to focus documentation on what has changed since the last visit. To this end, clinicians are not required to redocument mandatory elements in their note if the information has been previously reviewed and updated as needed. It should be stated in the medical record, however, that such a review has taken place.
- Acceptance of team-based documentation for both new and established visits. Specifically, clinicians need not document the patient's chief complaint and history if the information has already been entered into the record by supporting medical staff or a beneficiary. Clinicians may simply document/verify that the information has been reviewed.
- For clinicians in teaching settings, there no longer exists the requirement to duplicate components in the medical record that may have been previously included by residents or other trainees.

Beginning in calendar year 2021, notable changes aimed at simplifying payment and documentation requirements are set to take effect.[12] These include the following:

- Collapsing of the current 5 levels of new and established outpatient visit types into 3 levels—level 1, level 2 to 4, and level 5.
- Payment of level 2 to 4 visits will be at a single blended rate for both new and established patients; payment of level 5 visits will be maintained to account for the care and needs of more complex patients (Table).[13]
- Having the option for each type of visit to meet documentation requirements through (1) application of the current framework, (2) medical decision making, or (3) time.
  - When using the first 2 of these approaches for level 2 to 4 visits, a minimum supporting documentation standard exists requiring providers to only meet current level 2 requirements related to documenting the history, physical examination, and medical decision-making.
  - When using time-based documentation, medical necessity of the visit will need to be documented, and it should be attested that the billing provider spent the required amount of time face-to-face with the patient.
- Introduction of new add-on codes (only applicable to level 2 to 4 visits) outlining additional resources required for the visit by clinicians working in primary care and nonprocedural, medical specialties including cardiology.
- Introduction of a new extended visit add-on code (only applicable to level 2 to 4 visits) when clinicians require extra time spent with the patient.

Also finalized are important new codes related to services using technology.[12] These include new codes covering virtual check-ins (HCPCS code G2012) and remote evaluation of recorded video and images submitted by an established patient (HCPCS code G2010). The former was created for the betterment of clinicians and patients by paying for conversations via phone or another telecommunications device to decide whether an office visit or other services were needed. The latter was created to pay clinicians for review of store and forward video and images to assess whether a visit or other services were needed. Importantly, CMS is also finalizing new codes for chronic care physiologic monitoring (CPT codes 99453, 99454, and 99457) and interprofes-

Table. **Previous and Future E/M Payment Amounts**

	Complexity Level	Previous (2018) Payment	Revised Payment Amount*				
		Visit Alone	Visit Alone	Visit With Care Add-on Code	Visit With Extended Services Code	Visit With Add-on/Extended Services	Visit With Prolonged Code Added
New patient	Level 2	$76	$130	$143	$197†	$210	
	Level 3	$110					
	Level 4	$167					
	Level 5	$211	$211				$344‡
Established patient	Level 2	$45	$90	$103	$157†	$170	
	Level 3	$74					
	Level 4	$109					
	Level 5	$148	$148				$281‡

Adapted from Centers for Medicare & Medicaid Services, E&M Payment Amounts.[13]
*Amounts are based on 2019 payments rates and may differ in 2021 when the policy takes effect.
†Reimbursement listed is at 38 min for new patients and 34 min for established patients.
‡Reimbursement listed is at 90 min for new patients and 70 min for established patients.

sional consultation via the internet (CPT codes 99451, 99452, 99446, 99447, 99448, and 99449).

DISCUSSION

Although fairly uniform praise has been given to CMS for its desire to streamline and minimize documentation requirements for E/M visits, concern has been raised about the financial implications of a collapsed payment rate for the new level 2 to 4 visit, particularly among clinicians seeing patients with complex care needs. It has been estimated that the blended payment rate roughly equates to a level 3.35 visit for new patients and a level 3.45 visit for established patients. Clinicians who have historically billed for a greater number of level 2 and 3 visits will see an increase in payment; those who have billed for more level 4 visits will see a decrease in payment.

Assertions by CMS that the new policy maintains payment neutrality does not take into account the fact that distribution of billed visits may not be bell-shaped within a particular specialty. In cardiology, for example, greater patient complexity and a higher burden of comorbid conditions has in part accounted for a distribution of E/M visits skewed rightward, with far greater level 4 than level 2 visits. As a result, CMS has projected a 2% net reduction in payments to cardiologists with these changes. There exists no indication at the present time that specific subspecialties within cardiology are more likely to be affected. Those spending a greater percentage of time in the outpatient setting caring for more complex patients, however, are likely to see a greater impact.

Uncertainty currently exists as to whether these changes will also be adopted by commercial payers. There exist previous examples where CMS policy related to coding was not adopted (eg, the 2-midnight rule). Acceptance of CMS policy would certainly simplify E/M coding, however, likely at the expense of broader reduction in reimbursement for cardiologists. In contrast, failure to adopt this policy by commercial payers would necessitate clinicians either having to navigate 2 different E/M documentation standards or choosing 1 standard to be more broadly applied. With the latter approach, cardiologists could see even greater reduction in payment if the streamlined documentation standard (based on level 2 requirements) was applied to patients insured by commercial payers.

Concern has also been raised that lower reimbursement for some clinicians could incent shorter visits, further reducing face-to-face time with patients.[14] Beyond limiting attention to active medical issues, shorter visits have the potential to reduce patient and provider satisfaction,[15] lessen time for counseling and education,[16] and result in an overall lower quality interaction.[17] Shorter visits may also encourage greater use of documentation templates, which paradoxically, could perpetuate note bloat. Finally, for patients with complex care needs, shorter encounters are likely to result in more frequent office visits, a larger annual spend on copayments, and overall greater inconvenience.

Although this coding structure has been finalized for 2021, changes could still be made in future rulemaking. Before the rule's release, a large coalition of professional societies, the American Medical Association, and the CPT Editorial Panel encouraged CMS to rely on an American Medical Association workgroup to further address complicated issues related to documentation, coding, and payment.[17] In finalizing the changes for 2021, CMS noted that "a 2-year delay in implementation will provide the opportunity for us to respond to the work done by the American Medical Association

and the CPT Editorial Panel, as well as other stakeholders. We will consider any changes that are made to CPT coding for E/M services and recommendations regarding appropriate valuation of new or revised codes." In the interim, it is important that clinicians consult with their local documentation/coding experts to understand how current and future coding changes are likely to impact their workflow and reimbursement.

QUALITY IMPROVEMENT AND RESEARCH

For reasons stated previously, there exists an important need to study the effect of these coding changes on clinical practice, as a number of questions remain unanswered. For example, will simplified documentation requirements improve patient satisfaction, increase workforce wellness, and promote greater care coordination? Alternatively, if the proposed changes invite shorter visits, are certain populations more likely to be affected (eg, those with complex care needs), potentially leading to disparities in care? Further evaluation of the final rule's impact on health care delivery will certainly be needed before the aforementioned concerns can be affirmed or refuted.

Equally important is the need to improve the means by which clinicians document in the electronic health record. Today, it is fairly common for notes to be generated with text that is largely non-discrete. Although this approach affords great flexibility, it limits the ability to capture reusable clinical data that can be leveraged for quality improvement and research. Because most clinicians do not perceive this as their primary responsibility, workflows are needed which support integration of structured free text with coded discrete data fields as part of routine clinical care.[18] Smart forms, for example, hold promise as a means to facilitate documentation of the patient visit, while supporting data capture and delivery of actionable decision support.[19] Further research is needed, however, to determine how tools such as this should be implemented, particularly on the heels of increased efforts to streamline the documentation process.

CONCLUSIONS

Notes generated in electronic health records today infrequently achieve the primary goals for which they are intended. They generally are lengthy, suboptimally organized, and can detract from, rather than enhance, the care provided. CMS' *Patients Over Paperwork* initiative and the recently approved documentation requirements represent an effort to improve care delivery and remove contributors to clinician dissatisfaction and burnout.

Unfortunately, it currently remains unknown whether clinicians will take advantage of these changes to more clearly document their observations, thoughts, and recommended actions in service to improved care coordination—simply put, *streamlined notes don't necessarily mean better notes*. Furthermore, uncertainty exists as to whether the collapsed payment for level 2 to 4 visits will incent clinicians facing payment reductions to shorten their visits, even for those with complex care needs. In addition, commercial payers have not yet weighed in as to whether they will adopt CMS' recommendations. Failure to accept these changes will result in multiple coding schema and almost certain worsening of clinician dissatisfaction, simply by having to document in more than one way. In the end, only time will tell whether the changes put forth by CMS amount to the differences our patients and clinicians are all hoping for.

ARTICLE INFORMATION

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Disclosures

J. Vavricek is an employee of the American College of Cardiology. The opinions put forth, however, do not represent an official viewpoint by the American College of Cardiology. The other author reports no conflicts.

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