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Some Changes as a Result of the CMS Final Rule 2019

January 22, 2019

CMS 2019 Final Rule Changes	NGS Provider Points and Reminders
1. E/M Change: Home Health Visits CMS has removed the requirement for providers to document the medical necessity of furnishing a home visit rather than an office visit.	⇒ Effective 1/1/2019, providers no longer need to document the medical necessity of performing an E/M visit in the home rather than in the office setting. ⇒ CPT Codes impacted: 99201–99205, 99211–99215.
2. E/M Changes: Guidelines to FollowWhen to Expect Changes **CMS Final Rule excerpt:** "For CY 2019 and 2020, we will continue the current coding and payment structure for E/M office/outpatient visits, and, therefore, practitioners should continue to use either the 1995 or 1997 versions of the E/M guidelines to document E/M office/outpatient visits billed to Medicare for 2019 and 2020 (with the exception of our final policy to eliminate redundant data recording)."	⇒ For CY 2019–2020, the current coding and payment structure for E/M office/outpatient visits remains unchanged. ⇒ CPT Codes impacted: 99201–99205, 99211–99215. ⇒ When performing, documenting and billing for these services, providers should continue to follow the CMS 1995 and 1997 E/M guidelines, except for specific changes described below in this document. ⇒ Beginning in CY 2021, CMS plans to consolidate payment rates for E/M levels 2–4 and to implement additional time and specialty codes for E/M services, in addition to modifying documentation expectations. Additional educational information will be available as we approach CY 2021.
3. E/M Change: Use of Previous Documentation in a Medical Record **CMS Final Rule excerpt:** "We are finalizing our proposal that, effective January 1, 2019, for new and established patients for E/M office/outpatient visits, practitioners need not reenter in the medical record information on the patient's chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information. We note that this policy to simplify and reduce redundancy in documentation is optional for practitioners, and they may choose to continue the current process of entering, reentering and bringing forward information. The option to continue current documentation processes may be particularly important for practitioners who lack time to adjust workflows, templates and other aspects of their work by January 1, 2019."	⇒ As of 1/1/2019, for new and established E/M patient visits in the office and outpatient setting, providers may refer to previously documented information on the patient's chief complaint and history, which may have been entered in the medical record by ancillary staff or by the patient. ⇒ In a teaching hospital setting, this concept may apply to documentation entered by residents or medical students in both the outpatient and inpatient settings; please see below. ⇒ CPT codes impacted by this change in the office and outpatient setting: 99201–99205, 99211–99215. ⇒ CPT codes impacted in the **teaching hospital setting** include the outpatient codes above and also inpatient codes 99221–99223, 99231–99233. ⇒ Providers may continue to elicit this information independently, without support of ancillary staff or the patient.

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Cont'd	⇒ **Of note:** there is a clear expectation that complaint and history information, particularly HPI, be carefully reviewed and noted by the performing provider. In many circumstances, clinical skill is needed to determine the scope and course of questioning relative to this process; the provider remains obligated to assess previously recorded information and to expand upon it as medically necessary. ⇒ Previously recorded information on defined E/M elements (history, examination and medical decision making) may also be referred to in documentation for a visit, when there is clear evidence that the provider has reviewed this earlier information and either updated it as appropriate to the clinical scenario. ⇒ An example of this last point: "12/15/2018: Since last seen on 11/10/2018, no significant interval history. Physical examination remains unchanged except for drop in BP from 160/90 to 140/80 today on current Losartan regime. Will maintain all current meds and schedule return visit in early February 2019." ⇒ As referenced in the 2nd bullet, the concept of reviewing prior entries made by members of a **medical team in a teaching hospital,** including house staff and students, and modifying as necessary (but not repeating the prior info) is acceptable **in both the office and hospital environment.**