MDedge Dermatology News

Lemons into lemonade: The 2019 final rule

BY BRETT M. COLDIRON, MD

Medicare just released its 2019 physician fee schedule, which is called the "final rule." Of course, there is a new final rule every year, so it really isn't very final. I know this is confusing to many of you, I was dazed for several days by this year's proposed final rule.

Each year, the Centers for Medicare & Medicaid Services receives input from innumerable sources and formulates its payment for physicians. These responses are often in response to requests by CMS itself, which wants to make sure reimbursements are accurate.

Generally, input comes from the American Medical Association's RVS Update Committee (RUC), which values new and existing CPT codes, as well as Congress, the Health & Human Services Office of Inspector General, lobbyists, specialty society organizations, public advocacy groups, and anyone who can wrangle an appointment at or write a letter to CMS headquarters in Baltimore. This conflicted brew is hashed over, and published in late July as a proposed rule. Public comments are then solicited (all letters and emails are considered, dermatologists sent 1,500 responses to this one!) and a final rule is published in the fall.

This year's proposed rule was particularly disturbing because of major changes in reimbursement proposed by CMS. As you may recall, officials proposed to collapse all the evaluation and management (E/M) codes into two levels and pay bonuses to certain specialists (but not dermatologists). This might have been agreeable, except Medicare reimbursements are a zero-sum game. If someone is paid more, someone else will be paid less.

Of course, you could always let the increase come out of the general pool, but that would decrease the conversion factor, and some health care professionals (usually primary care) might not see an overall increase. So, the proposed rule was going to "pay" for this increase by way of eliminating the 25 modifier, the CPT modifier that allows you to be paid for the E/M service on the same day as a procedure. This has been averted, at least for 2 years.

The final rule also makes a real effort to eliminate some meaningless documentation. Effective Jan. 1, 2019, for established patients, practitioners can focus their notes on patient changes. With new and established patients, they need not personally reenter the chief complaint and history already recorded by staff or the patient, other than simply indicate that they reviewed and verified the information in the medical record. In addition, teaching physicians do not have to duplicate notations by residents. CMS also included practice expense for additional skin biopsies.

CMS is also going to pay for services using communication technology. These include:

- Brief communication technology-based service, e.g. virtual check-in (HCPCS code G2012). This is provided by a physician or other qualified health care professional who can report E/M services for an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion. It is important to note that CMS is allowing for this code to include audio-only, real-time telephone interactions, in addition to synchronous, two-way audio interactions that are enhanced with video or other kinds of data transmission.
- Remote evaluation of recorded video and/or images submitted by an established patient (HCPCS code G2010). This is remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment). The code can be reported effective Jan. 1, 2019, for established patients only.

You can use G2012 to decide if an office visit is needed. Similarly, the service of remote evaluation of recorded video and/or images submitted by an established patient would allow health care professionals to be paid separately for reviewing patient-transmitted photo or video information whether or not a visit is needed. The encounter must be synchronous (real-time), two-way audio interactions enhanced with video or other kinds of data transmission.

It appears that these would be practical only for established patients, and don't forget, your Internet and text responses to patients' messages are not secure, unless they are on a secure portal, although their messages to you are HIPAA compliant.

However, the telephone, some Internet portals, and your electronic medical record portals are secure. It is intriguing to me that I might get paid for all those bad pictures patients send me, at least if it is not in a global period.

It also appears that Rural Health Clinics and Federally Qualified Health Centers will be able to bill for new and established patient visits via communication technology.

This is all great news to physicians. Kudos to dermatologists Jack Resneck Jr., MD, American Medical Association trustee; George Hruza, MD, the American Academy of Dermatology president-elect; and Sabra Sullivan, MD, PhD, chair of the AAD's Council on Government Affairs and Health Policy Government, who organized this lemonade-making effort. And once again, the AAD's Washington office has shown its great value. This also clearly demonstrates why you write letters to CMS.

In 2021, levels 2-4 will be collapsed into one code (level 5 will remain, but remember, very few dermatologists use level 5) and you will have to document at only level 2 code levels. Special add-on codes will be included for exceptionally difficult cases for primary care and all specialist physicians, including dermatology.

What is not clear is how this new reimbursement schemata will be funded. CMS is still suspicious that there is overlapping work when procedures are performed on the same day as an E/M code. We may end up fighting this battle all over again.

Currently CMS is conducting a survey, sent to 1,500 dermatologists, on follow-up visits. CMS has stated that they will evaluate the public comments received and consider whether to propose action at a future date.

CMS plans to send a letter describing the requirements, once again, to health care professionals in nine affected states, who are required to report the global period encounter. If you are one of these practitioners, please do fill this out and contact Faith McNicholas at AAD (FMcNicholas@aad.org) if you have questions. The decision to eliminate global periods (disastrous) will be based on this survey.

This is why you need to stay engaged, write letters, join the AMA, donate to SkinPAC, and attend the legislative fly in, the AAD's legislative conference held every year in Washington.

We are a small specialty. If we do not speak up and stay engaged, we will become the lemons for the next pitcher of lemonade. ■

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