Medicare Payment, E/M Coding and RAC Updates
Emily L. Graham, RHIA, CCS-P
Hart Health Strategies, Inc.
January 14, 2020

Medicare Payment and E/M Coding

E/M Services

- In the CY 2019 MPFS, CMS finalized changes to the E/M documentation guidelines to reduce provider burden.
- CMS revisited its previously finalized policies regarding office/outpatient E/M visit documentation and payment, and has made the following changes as part of the CY 2020 MPFS:
  - Rescinded the collapse of payment rates for Levels 2-4 and a prolonged services code.
  - Adjusted the complexity add-on percentages to update CPT and RUC to reflect the new values.
  - Removed history & physical (H&P) requirements.
  - Allowing practitioners to choose medical decision-making (MDM) or time as basis for documentation.
  - Modifying the MDM criteria.
  - Eliminating W50.
  - Rescinded a shorter, time-based prolonged services code developed by AMA’s CPT Editorial Panel for use with Level 5 visits.
  - Consolidated previously rescinded complexity add-on codes into a single complex add-on code (GPC1X) with revised descriptor that could be billed with every level of office/outpatient E/M service.
- While these policies go into effect January 1, 2021, CMS acknowledged comments about the large redistributive effect these policies will have on the MPFS and conversion factor in CY 2021 and stated that it would consider whether to address this in CY 2021 rulemaking.

Photo credit: Architect of the Capitol
### E/M Service wRVUs

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>S11 RVUs</th>
<th>Finalized 2020 RVUs</th>
</tr>
</thead>
<tbody>
<tr>
<td>99201</td>
<td>0.40</td>
<td>Code eliminated</td>
</tr>
<tr>
<td>99202</td>
<td>0.95</td>
<td>0.99</td>
</tr>
<tr>
<td>99203</td>
<td>1.40</td>
<td>1.4</td>
</tr>
<tr>
<td>99204</td>
<td>2.40</td>
<td>2.4</td>
</tr>
<tr>
<td>99205</td>
<td>3.17</td>
<td>3.5</td>
</tr>
</tbody>
</table>

### New patient E/M services:

- 99201: 0.40
- 99202: 0.95
- 99203: 1.40
- 99204: 2.40
- 99205: 3.17

### Established patient E/M services:

- 99211: 0.18
- 99212: 0.48
- 99213: 0.97
- 99214: 1.5
- 99215: 2.11

### Add-on codes:

- Add-on for prolonged services (Level 5): N/A, 0.61
- Add-on for complexity (Level 5): 0.25, 0.33

---

### Care Management Services

- CMS finalized several changes for care management services, including:
  - For care management for a single serious chronic condition: CMS finalized G2054 and G2055 to account for Principal Care Management (PCM) services, which describe care management services for one serious chronic condition.
  - For care management of multiple chronic conditions: CMS finalized G2058, which reflects non-clinical staff time for Chronic Care Management (CCM) services.

---

### Communication technology-based services

- CMS finalized a policy to permit a single consent to be obtained, at least annually, for multiple communication technology-based services, including:
  - Virtual visits
  - Remote evaluation of images
  - Interprofessional consultation services
Impact of Medicare PFS on A/I

- **2020 Conversion Factor**
  - CMS set the CY 2020 conversion factor at $36.0896, a 0.14 percent increase over the CY 2019 conversion factor.

- **Impact on A/I**
  - For A/I, the estimated CY 2020 impact on total allowed charges of all relative value unit (RVU) changes is 0%.
  - The impact of the finalized E/M payment and coding policies is 7%.

---

Program Integrity

Medicare's Recovery Audit Program

- CMS' Recovery Audit program seeks to “detect and correct improper payments in the Medicare PFS program and provide information to CMS and its contractors that could help protect the Medicare Trust Funds by preventing future improper payments.”

- There are three (3) different Recovery Audit Contractors (RACs) that work to:
  - Detect and collect overpayments made to providers on claims of health care services provided to Medicare beneficiaries
  - Identify underpayments to providers so that CMS’s Medicare Administrative Contractors (MACs) can prevent future improper payments in all 50 states.
RACs must seek CMS’ approval before engaging on a specific topic.

Proposed and approved RAC topics are posted on CMS’ website for public feedback, and include the following information:

- Name of the Review Topic
- Description of what is being reviewed
- States / MAC regions where reviews will occur
- Review Type (complex review / automated review)
- Provider Types
- Affected Codes
- Applicable Policy References

Note that CMS receives referrals of potential improper payments from the MACs, UPICs, and investigative agencies (e.g., OIG, DOJ) that it may ask RACs to review.
Medicare RAC Topic of A/I Interest

Name of the Review Topic: 0161-Therapeutic, Prophylactic, and Diagnostic Injections and Infusions: Medical Necessity and Documentation Requirements

Description of what is being reviewed: Documentation will be reviewed to determine if correct billing, coding, and medical necessity guidelines for Therapeutic, Prophylactic, and Diagnostic Injections and Infusions were met.

States/MAC regions where reviews will occur: All A/B MACs

Review Type (complex review/automated review): Complex

Provider Types: Outpatient Hospital

Affected Codes: CPT codes 96365, 96366

Applicable Policy References: See list, which largely consists of Medicare manuals, etc.

Medicaid and RACs

- The Affordable Care Act (ACA) required each state Medicaid program to establish a Recovery Audit Contractor (RAC) program to identify overpayments and underpayments by Medicaid programs to physicians, hospitals, and other providers.

- The Medicaid RAC program is administered by the states, giving each state flexibility in terms of the design and operation of their program.

- There are significant variations in how the program works in each state (e.g., types of audits conducted, data types and formats required, appeals processes, and regulations).

- Many states have received exceptions from the RAC program and, therefore, do not have a RAC program in place.
Medicaid RAC Topic of A/I Interest

- Allergy services (i.e., CPT 95165) has been identified by Myers and Stauffer, LLC (MSLC), one of the Medicaid RAC auditors working with Georgia.

- MSLC audit agenda states:
  MSLC performed claims analysis of physician claims for services involving allergen immunotherapy, including allergy testing, antigen preparation and allergy injections, including but not limited to, Current Procedural Terminology (CPT) code 95165.
  MSLC completed its review of records requested from a number of physicians, and this review revealed potentially improper billing, including claims submitted for services performed by independent contractors. To date, recoveries have been obtained from a number of physicians who received initial findings of overpayments. MSLC has received several requests for administrative review and we are assisting the Department in handling these matters.

MACPAC Recommendation on Medicaid RACs

- As part of its June 2019 Report to the Congress, MACPAC made the following recommendation:
  - To provide states with flexibility in choosing program integrity strategies determined to be effective and demonstrate high value, Congress should amend Section 1903(a)(42)(B)(i) of the Social Security Act to make the requirement that states establish a recovery audit contractor program optional.
  - According to MACPAC, “…we found multiple concerns regarding statutory requirements that states contract with a recovery audit contractor (RAC). Many states have been unable to procure a RAC, forcing them to seek waivers from CMS. Other states are finding diminishing returns from RAC contracts, which also overlap with newer post-payment review activities.”

Now for the details…. Next Presenter:
Teresa Thompson, BS, CPC, CMCS, CCC