



CMS Final Rule on the 2019 Medicare Physician Fee Schedule

CMS issued its Final Rule for the 2019 Physician Fee Schedule which includes simplifications to evaluation and management (E/M) documentation but delays other changes.



Beginning January 1, 2019

- Medicare will allow ancillary staff to perform and record the chief complaint and history of present illnesses, reducing the unnecessary redundancy in documentation.
- Medicare will allow physicians to focus their documentation on what has changed/not changed since the established patient's last office/outpatient visit. Eliminating the need to re-record the defined list of required elements.

Limitations

The goal of the final rule is to reduce physicians' documentation burden. Short-term limitations are:

- Finalized rules do not take effect until 2021.
- Only applies to Medicare.
- Unless commercial payers adopt similar guidelines, providers may have different rules for different payers for a period of time.
- The rules only apply to office visit codes. Codes from various categories of E/M services (e.g. hospital care codes) should recognize the current documentation requirements.

Changes delayed until January 1, 2021

The proposed rule contains provisions including a single blended payment rate for office visit levels two through five for both new and established patient visits. Primary care physicians were concerned their payments would be substantially affected by the difference between the primary care add-on code and the \$17 payment bump offered for specialist visits. The final rule addresses that:

- Medicare will pursue a blended payment rate, but only apply it to levels two through four.
- Level-five office visits will be left as an option for the most complex patients.
- Effective date of the blended payment rate is January 2021.
- The proposed differential payment for primary care and specialty care add-on codes that may be reported in conjunction with the blended payment would be valued the same.
- The add-on code for inherent complexity can be reported in conjunction with the level of E/M service once the blended payment concept is applied to level-two through level-four office visits.
- Documentation requirements will be relaxed once the new blended payment takes effect in 2021.
- Providers will be able to code visits based solely on the medical decision making component of the E/M service, regardless of whether criteria for history or exams are met.
- Providers will be able to select a level of service based on time. Documenting that they spent the time described by each level of service face-to-face with the patient.



Dates to Remember

December 14, 2018

Deadline to alert your practice coach regarding any physician changes, e.g. additions, drops, and address changes.

January 19, 2019 (midnight)

Deadline for entering 2018 gaps in care data in Health e-Blue for BCN, BCBSM COMMERCIAL and Medicare Advantage. Submission of EMR files is **February 8**.

WEBINAR – January 17, 2019

BCBSM PCMH and PCMH-N Interpretive Guideline Updates – new changes, additions, and/or deletions. You won't want to miss this one! Watch your emails for more information and to register.

2019 Webinars and Newsletters

CIPA will be alternating webinars and newsletters in 2019. Webinars will be in odd months (January, March, etc.) and newsletters will be in even months.

Year End Countdown

So, you have less than one month to complete your projects for PCMH nomination and close gaps in care. Where do you focus? Here are some tips to get you to the finish line.

- Pull your patient gaps list from Carespective and/or HEB.
- Identify those patients with gaps that need an appointment and schedule them before the end of the year, allowing enough time to reschedule for cancellations. Add a note in the schedule so staff know to not allow patient to cancel.
- From the above list identify patients that can be scheduled for a nurse visit if they need labs done, etc.
- Identify measures that need Health e-Blue (HeB) entry such as counseling for nutrition or blood pressure control and enter in HeB.
- From the Carespective list identify measures that need follow up calls for services not completed or done elsewhere, such as colorectal cancer screening, mammograms, eye exams, etc., both to facilities and patients. Encourage patients to complete services and provide education on importance where appropriate. Assist patients in scheduling services before the end of the year.
- During down time, have staff review the chronic care model and PCMH PowerPoints (available on Carespective).
- In staff meetings, review your policies for test tracking, referrals, and community resources. Conduct a game matching services to a community organization.
- Create a health education bulletin board in the break room and assign staff to update it monthly or quarterly.

If you need assistance on how to pull reports from Carespective to close gaps, please contact your practice consultant.

**Wishing you and your family
the best this holiday season.**

Medical Advantage Group and
CIPA offices will be closed on:

December 24, 2018

December 25, 2018

January 1, 2019



Consortium of Independent Physician Associations



DOMAIN 6: Test Results Tracking and Follow-up

As an integral component of the PCMH-N framework, the intent of the Test Tracking and Follow-Up Initiative (Domain 6) is to implement a standardized and reliable system to ensure that patients receive necessary tests, test results are communicated in a timely manner, follow-up appropriate to the patient's care is conducted and each step in the test tracking process is properly documented. By achieving the goals of Domain 6 as outlined by the PCMH/PCMH-N program, providers will realize the benefits of optimized interactions between testing facilities and relevant providers, including appropriate flow of necessary patient testing information and results, and support for patient-centered, high quality care.

In addition to allowing for timely communication of test results, the optimal test tracking and follow-up process developed through the implementation of capabilities outlined in Domain 6 of the PCMH/PCMH-N program establish clear expectations for interactions between testing facilities, providers and patients. By refining the test tracking and follow-up process, practices and providers develop clear guidelines for communicating relevant patient information necessary for scheduling appropriate tests, tracking the life cycle of a pending test, retrieving relevant test results and communicating normal and abnormal test results in a timely manner. These steps allow providers to actively monitor the status of outstanding test results, and conduct and/or recommend any appropriate follow-up care that may be required for the patient as they progress through their healthcare journey.

As primary care providers and specialty care providers commit to refining their process to allow for this type of communication and integration, not only do they realize the benefits of timely communication and follow up, but most importantly, their patient populations experience the benefits of an improved patient experience of care across the care continuum.

The test tracking process and documented procedure needs to be reviewed annually to ensure consistency among all staff members. Incorporating it into annual training requirements and new hire education is a simple method to accomplish this goal.

