Payment methodologies: Industry trends and best practices

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Lisa began her Optum career reviewing clinical appeals then went on to RAVE to assist in resolving provider escalations. She then moved on to her current Ideation role in Payment Integrity where she identifies areas of opportunity and works with appropriate teams to solution. She is a graduate of Rutgers University and was recently awarded the Optum Super Hero Award. This award is given to those individuals that provide exceptional service to our customers and make a difference in the lives of those we serve.

Lisa holds the following certifications:

- Certified Professional Coder (CPC)
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- Certified Emergency Department Coder (CEDC)
- Certified Pharmacy Technician (CPhT)

There are two general domains for payment methodologies within the health care practice area: one for medical services and the other for prescription drugs. Within each of these domains, there are various classifications. The following table shows the major classifications:

MEDICAL SERVICES

- DRG Diagnosis-related Group
- APC — Ambulatory Payment Classification
- APG — Ambulatory Patient Group
- POC — Percent of Charge
- FS — Fee Schedule (physician, durable medical equipment (DME), lab, etc.)

PRESCRIPTION DRUGS

- FS Fee Schedule
- AWP — Average Wholesale Price
- WAC — Wholesale Acquisition Cost
- AAC — Actual Acquisition Cost
- ASP — Average Sales Price
- NADAC — National Average Drug Acquisition Costs

Each methodology is set up differently – be sure you have an understanding of how medical services and prescriptions drugs are priced to be sure the pricing you are receiving is appropriate.

Final rule issued to streamline E/M payments

The Centers for Medicare & Medicaid Services (CMS) issued a final rule on November 1, 2018 to streamline evaluation and management (E/M) payments. The purpose of the changes is to reduce the administrative burden of documentation requirements for providers and also improve payment accuracy for E/M office and outpatient visits.

CMS is finalizing a number of documentation, coding and payment changes that will take place over several years. For calendar years 2019 and 2020, several documentation policies will be implemented to reduce the burden immediately, while other changes to documentation, coding and payment will be implemented in the 2021 calendar year. No significant changes were made to payment codes.

Final rule changes to be implemented in 2019

For calendar years 2019 and 2020, CMS will continue the current coding and payment structure for E/M office and outpatient visits. The last update to E/M codes was 1997. CMS has a new initiative called Patients-Over-Paperwork. This new initiative was prompted by provider complaints to CMS about having to do a lot of paperwork for an E/M code (history, exam, medical decision making).

CMS began using these blended payment rates in some facility settings and they have worked well the past two years. The rules now extend to professional E/M services. CMS is to have a blended payment rate for:

- A new patient.
- An established patient for levels two through five visits.

Practitioners should continue to use either the 1995 or 1997 E/M documentation guidelines to document E/M office and outpatient visits billed to Medicare.

For calendar year 2019 and beyond, CMS is finalizing the following policies:

- Eliminate the requirement to document medical necessity of a home visit instead of an office visit. This will need to be evaluated for how Optum reviews documentation today and adjust reviews accordingly.
- For established patient office or outpatient visits, when relevant information is already in the medical record, practitioners may choose to focus on:
  - Documentation that has changed since the last visit
  - Pertinent items that have not changed since the last visit

Practitioners will not need to re-record the defined list of required elements if there is evidence that they reviewed and updated previous information as needed.

Practitioners should still review prior data, update as necessary and document those activities in the medical record. Records reviewed will need to be evaluated and determined how to address inconsistencies that may be within the records.

- Additionally, CMS clarified that for E/M office and outpatient visits for new and established patients:
  - Practitioners do not need to re-enter the patient's chief complaint and history if it has already been recorded by ancillary staff or the beneficiary in the medical record information. The practitioner may indicate in the medical record that he/she reviewed and verified this information. This should not impact Optum reviews.
  - Remove potentially duplicative requirements for notations in medical records that may have been included in the medical records previously by residents or other members of the medical team for E/M visits furnished by teaching physicians. This should not impact Optum reviews.

CMS is not finalizing the following three areas at this time:

1. Modifier 25 payment reduction of 50 percent
2. Podiatry code additions
3. Standardizing the allocation of practice expense Relative Value Units (RVU)

Beginning in 2021, CMS will continue to **reduce the burdens** of implementation of payment, coding and other documentation changes.

Major payment and documentation changes to come in calendar year 2021

Beginning in 2021, CMS will continue to reduce the burdens of implementation of payment, coding and other documentation changes:

- Payment for E/M office and outpatient visits will be simplified.
- Payment will vary primarily based on attributes that do not require separate, complex documentation.
- Addition of new add-on codes to increase payments. Payment structure is due to change to have three levels of payment
  - 99201/99211
  - 99202-99204/99212-99214
  - 99205/99215
- Medical Decision Making(MDM), time or the current framework is at the discretion of the provider to code from

The following table outlines the policies CMS is finalizing for 2021, related to E/M office and outpatient visits:

E/M office and outpatient visit level	Changes
Levels 2 through 4	• Reduce payment variation by paying a single rate for established and new patients • When using MDM or current framework to document the visit, CMS will also apply a minimum supporting documentation standard associated with level 2 visits. For these cases, Medicare will require information to support a level 2 E/M office and outpatient visit code for history, exam and/or medical decision-making. • Implement add-on codes describing the additional resources inherent in visits for primary care and particular kinds of non-procedural specialized medical care, though they would not be restricted by physician specialty. Their use generally will not impose new per-visit documentation requirements. • Adopt a new "extended visit" add-on code to account for additional resources required when practitioners need to spend extended time with the patient.
Levels 2 through 5	• Permit practitioners to document E/M office and outpatient visits using either medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines. Alternatively, practitioners could continue using the current framework. • CMS will allow flexibility in how visit levels are documented. They can choose: the current framework, MDM or time.
Level 5 only	• Maintain payment rate to better account for the care and needs of complex patients.
All visit levels	• When time is used to document, practitioners will document medical necessity of the visit and that the billing practitioner personally spent the required amount of time face-to-face with the beneficiary.

CMS believes the policies outlined above will allow practitioners greater flexibility to exercise clinical judgment in documentation, so they can focus on what is clinically relevant and medically necessary for the beneficiary. While these changes are intended to decrease the provider paperwork burden, it should shift the focus to medical decision making and the elements that go into patient care. Providers will have the choice to use the 1995 and 1997 guidelines.

CMS intends to engage in further discussions with the public to further refine the policies for calendar year 2021. Note: the American Medical Association (AMA) might re-vamp the codes prior to 2021.

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Steps you can take now to prepare for the changes

Market observations show that most health plans are staying aware of the issue. They continue to monitor trends proactively and address issues as they arise such as aberrant billing patterns to recover overpayments.

Health plans may want to continue to evaluate their percent-of-charge providers. If an increase spikes when providers are billing to such a high amount compared to what they are being paid, reevaluate if that contract is appropriate and want to keep the methodology in place.

It's best to proactively align with the changes now so systems can get into place sooner rather than later. These steps may help avoid pay and chase scenarios which cause provider abrasion:

- Provide data analysis to determine magnitude of impact the proposal will have.
- Align commercial products to the CMS payment methodology to be consistent with providers and payment systems.
- Help health plans prepare systems and contracts for upcoming changes so they are ready (loading fee schedules, updating the network).
- Educate providers to ease the burden of upcoming changes.

To learn more about Optum payment integrity solutions, visit **optum.com/paymentintegrity**

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