OPINION

Update on Relative Value Units and the Cognitive Physician Visit

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In a previous opinion piece, we examined how the Medicare Resource-Based Relative Value Scale undervalued cognitive office efforts, particularly the inflammatory bowel disease (IBD) office visit.[1] Office visits for an established patient requiring low to high levels of medical decision-making have a relative value unit (RVU) in the range of 0.97 (Current Procedural Terminology [CPT] code 99213, office visit level 3) to 2.11 (CPT code 99215, office visit level 5). However, procedures such as colonoscopy are assigned a RVU between 3.26 and 5.24 depending upon the procedure (CPT codes 45378-45389).[2] Thus, the care of patients with chronic, complex diseases such as IBD, which requires time-consuming office visits, has low compensation and cannot compete with multiple procedures such as colonoscopies that could be performed in the same time allotment. In this opinion piece, we will examine the 2017 RVU coding update and when the new billing codes should be considered.

Centers for Medicare and Medicaid Services 2017 Annual Coding Update

In 2017, the Centers for Medicare and Medicaid Services (CMS) released an update for RVU coding. Office visit RVUs remain unchanged, and procedure RVUs decreased. The primary reason for this reduction is that moderate sedation was unbundled from the procedure codes, allowing moderate sedation to be billed in addition to the procedure. RVUs for prolonged services have increased (Table 1). Additionally, CMS will cover non–face-to-face prolonged services,[3] which is beneficial for specialists who may spend considerable time reviewing patient records and consulting with other providers (Table 2).

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When should these codes be used? Physicians should consider using prolonged services billing codes when a patient is noncompliant with the chosen treatment options, a patient has difficulty understanding the physician because of mental handicaps or language barriers, the physician has to explain complex treatment options such as surgery, or the physician has to explain essential lifestyle changes to the patient.

Another change in the 2017 update is a new code for the creation of a care plan for patients enrolling in chronic care management, which is geared toward the primary care physician. Chronic care management allows physicians who are coordinating care for chronically ill patients to bill for non–face-to-face care coordination services each month.[3,4]

What are the responsibilities of these services? Clinical responsibilities for face-to-face prolonged services include appropriate and sufficient documentation of dates, start and end times when using time-based codes, and physician documentation of at least an additional 20 minutes beyond the reference time of the chosen evaluation and management service. Documentation must explain why the physician provided prolonged services; simply noting that the physician spent an extra 60 minutes with the patient is not adequate to support a claim. Physicians should be careful not to include extra time, which may invite an audit (Table 3).

In contrast, clinical responsibilities for non–face-to-face prolonged services require a minimum of an additional 30 minutes on the patient's indirect care. This prolonged service may be performed on a different date than the primary service to which it is related. Carefully documenting time and briefly describing the work that was done are essential. The challenge, however, is to explain this charge to patients who may be responsible for deductibles and coinsurance, requiring clarification of what this service represents.

Table 1. Prolonged Services With Patient Contact

CPT Code	Type of Service	RVU	
		2016	2017
99354	Prolonged evaluation and management service (beyond the typical service time of the primary procedure) when a patient requires an extended visit	1.77	2.33
99355	Prolonged evaluation and management service (beyond the typical service time of the primary procedure) in the office or other outpatient setting requiring direct patient contact beyond the usual service, each additional 30 minutes. This code should be listed separately in addition to the CPT code for prolonged service, 99354.	1.77	1.77
99497	Advanced directives such as standard forms should be explained and discussed face-to-face with the patient, family member(s), and/or surrogate.	1.50	1.50
99498	Advanced care planning, each additional 30 minutes	1.40	1.40

CPT, Current Procedural Terminology; RVU, relative value unit.

Table 2. Prolonged Services Without Patient Contact

CPT Code	Type of Service	RVU	Clinical Responsibilities
99358	Prolonged evaluation and management service before and/or after direct patient care, first hour	2.10	For first-hour code 99358, the physician should spend a minimum of an additional 30 minutes on the patient's indirect care. For this service, the physician puts extra effort and time into the treatment of the patient.
99359	Prolonged evaluation and management service before and/or after direct patient care, each additional 30 minutes. This code should be listed separately in addition to the CPT code for prolonged service.	1.00	The physician should spend a minimum of an additional 15 minutes after the first hour on the patient's indirect care.

CPT, Current Procedural Terminology; RVU, relative value unit.

Table 3. Time Chart for Prolonged Services With Patient Contact

Evaluation and Management CPT Code	Typical Time (minutes)	Threshold Time to Bill CPT Code 99354 (minutes)	Threshold Time to Bill CPT Codes 99354 and 99355 (minutes)
99203	30	60	105
99204	45	75	120
99205	60	90	135
99213	15	45	90
99214	25	55	100
99215	40	70	115

CPT, Current Procedural Terminology.

Moderate sedation may now be billed separately if it is provided by the same physician or another qualified health care professional who performs a gastrointestinal endoscopic service. Time must be reported, with a minimum of 10 minutes of moderate sedation provided, in order to bill insurance carriers or patients. The medical record must reflect the presence of an independently trained observer.

Conclusion

These changes in coding are the first step in the process of improving the existing system. Physicians should advocate for themselves as well as for patients and explain that greater cognitive visit reimbursement is needed to ensure competent and informed medical treatment. Although

CMS does not have an open comment section regarding RVUs at present, physicians with RVU commitments may contact the American College of Gastroenterology Gastrointestinal Circle or their American College of Gastroenterology governor to register their concerns.

Dr Katz has conducted various industry-led clinical research trials. However, all fees, consults, and/or honoraria are made out to the New York University School of Medicine and not to Dr Katz. Ms Petrilak has no relevant conflicts of interest to disclose.

References

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