Impact of Medicare Office Visit Payment Reform on Urologic Practices

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OBJECTIVE
To evaluate the 2019 Medicare Physician Fee Schedule, which modifies reimbursement for office evaluation and management (E&M) visits. This policy moves payment to a single rate for levels 2 through 4 office E&M visits, regardless of complexity.

METHODS
Using a 20% sample of 2015 National Medicare claims, we identified urologic practices and their practice organization, academic affiliation, and degree of office focus (ie, proportion of revenues from office visits). Using billing data for each practice, we calculated the revenues expected under the current system and the new policy (both E&M payments and a new add-on code). For each practice, we determined the impact of new payment rates on total Medicare payments.

RESULTS
We identified 2822 practices: 1372 (48.6%) solo practices, 1033 (36.6%) multispecialty groups, 322 (11.4%) small urology groups, and 95 (3.4%) large urology groups. Under the new reimbursement rates, the median practice would have a 0.9% increase in Medicare Part B payments (range −20.4% to +50.3%) and, with the add-on code, an increase of 6.8% (range −7.5% to +74.9%). Solo practices had the most heterogeneity, with a quarter losing at least 2.3%. The median multispecialty group would increase payments by 0.4% (range −13.7% to 50.3%). However, the 107 (10.4%) academic multispecialty groups had a median gain of only 0.1% (range −2.8% to +8.1%).

CONCLUSION
Urology groups would, on average, benefit from the anticipated change in Medicare office E&M visit payments. However, solo practices with a high office focus and academic multispecialty practices may see reduced Medicare payments.

Office evaluation and management (E&M) visits are the most common physician services and accounted for approximately $23 billion in Medicare spending in 2017. Payment for these services is directed by the Medicare Physician Fee Schedule, which currently divides office visits into 5 levels with increasing fees commensurate with the increasing complexity of providing the service (Table 1). Since the adoption of documentation guidelines in the mid-1990s, the Centers for Medicare & Medicaid Services (CMS) has required specific documentation to justify the visit level billed. These guidelines were immediately unpopular among physicians, who criticized government intrusion into medical decision-making, the time-consuming paperwork, and complexity of the administrative burden implied by the change.

As part of its effort to put “patients over paperwork,” CMS announced revisions to the leveling policy in November 2018. The revised payment policy, effective January 2021, reduces documentation requirements and merges payments for levels 2 through 4 to a single weighted average rate. CMS has argued that this payment reform would reduce administrative burden on both the provider and payer, eliminate distinctions between visit levels that were largely outdated, and decrease the potential for fraud. Responding to concerns from physicians, policymakers also maintained that there would be minimal effect on payments to any given specialty. While the policy change intended to hold payment relatively neutral within a specialty, the possibility of disproportionate gains and/or losses looms large as patient complexity and leveling patterns likely vary considerably across different practice contexts. For instance, referral-based practices, such as those in academic medical centers, plausibly see a more complex patient population than a small community practice.

For these reasons, we performed a study to understand the effects of payment policy reform on urologic practices. Specifically, we used national Medicare data to

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characterize the consequences across a variety of meaningful practice contexts to help stakeholders anticipate and plan for the upcoming change.

METHODS

Study Population

Using a 20% national sample of Part B Medicare claims from 2015, we identified all office E&M visits (Current Procedural Terminology codes 99201 through 99205 [new patient visits] and 99211 through 99215 [established patient visits]). This captured all leveling codes that are included in the policy change that takes effect from January 1, 2021. We then identified the provider associated with all qualifying E&M payments using their National Provider Identifier number and characterized their specialty using explicit codes within the claims. We assigned each urologist to their practice context using the Medicare Data on Provider Practice and Specialty file from the Centers for Medicare and Medicaid Services. For this study, we included all group practices that included at least one urologist (n = 2981 group practices). Of these, we excluded those in the bottom fifth percentile for total Medicare Part B payments in 2015 (n = 116 group practices). These 116 excluded practices were primarily solo practitioners (91.8%) and had average Medicare payments of only $10,285 for 2015.

Characterizing Group Practice Contexts

We characterized practices based on an established framework for thinking about relationships between practice context and healthcare delivery. Practices with 1 or 2 urologists were considered a “solo” practice. For those comprised of 3 or more physicians, practices in which the majority of physicians were urologists were regarded as “single specialty groups.” For these practices, we further characterized them based on size. Those with fewer than 10 urologists were categorized as “small” and those with 10 or more urologists were categorized as “large.” Group practices in which the minority of physicians was urologists were labeled “multispecialty groups.” We then characterized these practices in a manner to test specific hypotheses related to payment reform. First, we hypothesized that groups who earned less of their Medicare revenue from procedures (ie, an office-based focus) would be disproportionately affected by the leveling change. At the practice level, we measured the proportion of all Medicare Part B payments due to 1 of the 10 E&M codes. For each practice, this was calculated by dividing the sum of all payments for E&M visits by the sum of all Part B payments. We used price-standardized payments to eliminate any variation in payment related to geography. Second, we hypothesized that practices that treat a disproportionate share of complex patients (and thus potentially use level 4 more commonly), such as those affiliated with an academic medical center or medical school practice, might be negatively affected by the policy. Using data provided by the Department of Health and Human Services, we identified group practices are associated with a medical school or academic medical center.

Outcomes

The primary outcome of the study was the percentage change in Medicare Part B payment associated with the new payment policy. This outcome measure was calculated based on the pattern of billed E&M visits for each practice. Using prices from current payment policy, we measured total payments for all E&M visits. Next, we characterized these payments based on prices from the new 2021 payment rules (Table 1). Finally, we divided the difference in current and anticipated payments by the total Part B payments for each practice, thus measuring the percent change in Medicare Part B revenue that would result from the policy change for each practice. We chose this relative measure as our primary outcome to help standardize policy effects across practices of different sizes.

As part of the final rule, CMS created a new “add-on” code meant to increase reimbursement related to the inherent visit complexity of nonprocedural specialty care. In essence, this add-on code can be billed with all level 2 through 4 E&M visits performed by urologists and would increase the revenues for these visits by a fixed amount (ie, approximately $13 per visit). All analyses examined the effect of the policy change with and without this add-on code.

Statistical Analysis

We used Pearson’s chi-squared test to assess relationships between practice context and the percent change in Medicare Part B payments. We used multiple linear regression to identify practice characteristics associated with changes in Medicare payment. For these models, the dependent variable was the percent change in Part B payment measured at the practice level. Independent variables included group practice organization (eg, solo, small single specialty, large single specialty, and multispecialty), academic medical group status, and extent of a practice’s office focus.

All statistical analysis was performed using SAS v9.4 (Cary, NC) and Stata 15 (College Station, TX). All tests were 2-tailed and alpha was set at 0.05. This study was deemed exempt from Institutional Review Board approval.

Table 1. Current and anticipated standardized payment rates for office E&M visits.

<table>
<thead>
<tr>
<th>Visit Level</th>
<th>CPT Code</th>
<th>2018 Payment ($)</th>
<th>2021 Payment ($)</th>
<th>2021 Payment With Add-on Code ($)</th>
</tr>
</thead>
<tbody>
<tr>
<td>New patient visits</td>
<td>1</td>
<td>99201</td>
<td>45</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>99202</td>
<td>76</td>
<td>130</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>99203</td>
<td>110</td>
<td>130</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>99204</td>
<td>167</td>
<td>130</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>99205</td>
<td>211</td>
<td>212</td>
</tr>
<tr>
<td>Established patient visits</td>
<td>1</td>
<td>99211</td>
<td>22</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>99212</td>
<td>45</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>99213</td>
<td>74</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>4</td>
<td>99214</td>
<td>109</td>
<td>90</td>
</tr>
<tr>
<td></td>
<td>5</td>
<td>99215</td>
<td>148</td>
<td>149</td>
</tr>
</tbody>
</table>
RESULTS

Of the 2822 group practices with meaningful participation in the Medicare program, 1372 (48.6%) were solo practices, 1033 (36.6%) were multispecialty groups, 322 (11.4%) were small single specialty urology groups, and 95 (3.4%) were large single specialty groups. The distribution of visit types for each type of practice is depicted in the Supplemental Figure.

Table 2 presents the characteristics and the percent change in Part B payments by group practice context. Under the 2021 payment rates, practices would have a net increase of 0.9% in Medicare Part B payments (range $-20.4% to +50.3%) on average. With the add-on code, practices would realize a net increase of 6.8% (range $-7.5% to +74.9%) of Medicare Part B revenue. Among the 1789 practices primarily composed of urologists (ie, excluding multispecialty groups), the median change in Medicare payment was +1.9% (range $-20.4% to +48.7%). With the add-on code, the average urology group would gain 7.9% (range $-7.3% to +62.8%) in Part B payments.

DISCUSSION
Medicare’s change to office E&M visit payment, set to go into effect in 2021, will be beneficial for most urologic practices if the policy is implemented as currently stated and payment for other sources of Part B revenue remain at current levels. On average, urology groups will increase Medicare Part B payments by between 0.9% and 6.8%. Smaller practices stand to benefit the most, but these groups will also have the most heterogeneity in the policy’s impact. While there is some concern that practices treated by diminished Medicare Part B payments, small single specialty urology groups will likely see a larger impact. Finally, with increasing office focus (for each 1% of Part B payments derived from E&M visits, a group would lose 0.2% of total Medicare Part B payments).

Table 2. Characteristics of urologic practices by group practice context

<table>
<thead>
<tr>
<th>Organization Type</th>
<th>Solo</th>
<th>Small Single Specialty Urology Group</th>
<th>Large Single Specialty Urology Group</th>
<th>Multispecialty Group</th>
<th>P Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of groups</td>
<td>1372</td>
<td>322</td>
<td>95</td>
<td>1033</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Total number of urologists</td>
<td>1534</td>
<td>1,497</td>
<td>2,004</td>
<td>4,351</td>
<td></td>
</tr>
<tr>
<td>Average number of physicians per practice, median (IQR)</td>
<td>1 (1-1)</td>
<td>4 (3-6)</td>
<td>17 (13-28)</td>
<td>76 (26-12)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Total Part B revenues ($)</td>
<td>37,538 (21,082-65,659)</td>
<td>201,922 (125,845-338,595)</td>
<td>1,072,940 (529,244-1,910,167)</td>
<td>1,282,124 (378,426-1,497,657)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Proportion of Part B revenues from office E&amp;M visits, median (IQR)</td>
<td>.39 (.3-.47)</td>
<td>.35 (.29-.4)</td>
<td>.25 (.21-.31)</td>
<td>.3 (.23-.39)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Academic practices, n (%)</td>
<td>1 (0.1%)</td>
<td>3 (0.9%)</td>
<td>5 (5.3%)</td>
<td>107 (10.4%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Percent change in Medicare Part B revenues, median (IQR)</td>
<td>From E&amp;M code change only</td>
<td>2.7 (−2.3-8.2)</td>
<td>1.4 (−1.3-4.1)</td>
<td>0.55 (−0.95-1.4)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td></td>
<td>E&amp;M code change with add-on code</td>
<td>8.9 (2.7-16)</td>
<td>7.2 (4-11)</td>
<td>4.7 (3.2-6.3)</td>
<td>&lt;.001</td>
</tr>
</tbody>
</table>
associated with E&M visit levels have been implicated in creating busy work for physicians,\(^{11}\) in motivating the development of billing-centric electronic medical record systems,\(^ {13}\) and in worsening physician burnout.\(^ {14}\) CMS’s efforts to simplify the documentation and payment system might have been well received, but for concerns about reduced reimbursement for physicians.\(^ {15}\) While CMS’s analysis in the final rule suggests that the policy change will not meaningfully affect the distribution of payments among various medical specialties, there is the potential for significant effects on a subset of practices.

We found that urologic practices would, on average, benefit from the proposed changes in office visit reimbursement. However, there is considerable heterogeneity in the effect of this policy among individual practices, particularly among solo practices. Therefore, urology groups may estimate the impact of this payment change by examining their own Medicare billing patterns and using the current and future payment rates in Table 1. By setting the payments for levels 2 through 4 office E&M visits to a single rate that is between the current payment for level 3 and level 4 visits, this policy increases Part B payments for practices that bill mostly level 2 and 3 visits and reduce total revenue for those that bill a disproportionate share of level 4 visits. As surgical specialists who generate revenue both from office visits and procedures,

**Figure 1.** Impact of evaluation and management (E&M) payment changes on Medicare Part B payments for 1789 urology group practices without (A) and with (B) new add-on code.
urologists may not be affected to the same degree as non-procedural physicians who rely solely on revenue from office visits.

Interestingly, there are some practices that stand to see large gains or losses in total Medicare Part B payments, with shifts of over 20% in either direction. Solo urology practices appear to be especially vulnerable to large changes as a result of policy. This is likely because solo practices tend to generate a larger proportion of their revenue from office visits. Conversely, larger urology groups may moderate the impact of this payment change by generating more revenues from procedures. Not only are office visits payments a small part of the overall revenue for these practices, but they often lead to additional procedures, which may further mitigate any negative effects of the payment policy changes.

In this study, we assessed the effects of E&M visit payment changes with and without the use of the newly created add-on code. CMS has indicated that these E&M payment changes should be budget neutral, and in the initial proposed rule, had included reductions to counteract the additional payments associated with the add-on code. However, in the final rule, these payment reductions were removed. Because it is unlikely that CMS plans to globally increase physician payments, we anticipate that subsequent policy will reduce payments for other Physician Fee Schedule services in order to achieve budget neutrality. As those anticipated reductions and their

Figure 2. Impact of E&M payment changes on Medicare Part B payments for 1033 multispecialty groups without (A) and with (B) new add-on code.
effects across practice contexts are unknown, we expect that the payment changes modeled here represent the upper bound of the actual effect that can be expected once the policy is implemented.

This analysis assumes that E&M leveling patterns will remain stable once new payment policy is implemented. Whether this is true or not is unclear. Incentives created by this new payment policy favor the provision of a higher volume of low-level (ie, simpler and shorter) office visits. It is possible that some group practices will elect to increase the volume of visits and limit longer visits to maximize revenues. Such a shift could worsen access for complex patients who need high-level medical decision-making or the management of multiple chronic issues. If practices attempt to focus office visits on one or two problems and schedule multiple visits for complex patients who require additional care, it could create an additional financial and logistical burden on patients.

CONCLUSION

The Medicare Physician Fee Schedule 2019 rule alters longstanding reimbursement rates for office E&M visits. Overall, urologic practices stand to increase Medicare Part B payments as a result of this policy change. By simplifying the leveling system, this policy change may create financial pressures on multispecialty academic groups and groups that see disproportionately complex patients. Depending on their current practice patterns, solo urologic practices may see large shifts in their Medicare revenue as a result of this new policy.

SUPPLEMENTARY MATERIALS

Supplementary material associated with this article can be found in the online version at https://doi.org/10.1016/j.jurology.2019.01.013.

References