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Proposed Rule¶
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Part II

Department of
Health and Human
Services
Centers for Medicare & Medicaid Services

CMS Wants to Change the Documentation Guidelines

The Proposed Rule for the Medicare Physician Fee Schedule is out now for changes they're proposing for payment policies in 2018 and the Documentation Guidelines are now in question.

The 1995 DGs have largely worked well for physician coders and auditors, giving just enough direction on content required for each visit level without being too restrictive in documentation as to make them clinically inconsistent with good patient care. Many would not agree with that, typically those who want less restrictions, not more.

But, the coding and the auditing communities have worked hard to find ways to interpret the 1995 DGs over the more than 20 years they have been around.

Payers argue over whether MDM risk is assigned based on presenting problems or final diagnoses, or, what a complete system review is when the finishing statement "all other systems negative" is involved, We argue over how many points to give for an emergency patient who has additional workup planned but not performed, or whether to give points when a diagnostic interpretive service is billed separately, and so forth. There are clear differences of interpretation, but it's a conversation we're all familiar with, positions have been taken and arguments are mostly limited to a few hermeneutical points.

CMS is now considering eliminating the History and Exam components while rewriting the MDM components. The part that worries us most is that they want to *"update MDM guidelines to foster appropriate documentation for patient care commensurate with the level of patient complexity, while avoiding burdensome documentation requirements and/or inappropriate upcoding."* See the complete text from the Proposed Rule in the pages below.

Medical decision-making is a complex process that starts with the nature of the presenting problem and past medical history involving comorbidities, current medications and findings from the history and exam. These lead to differential diagnoses that are reflected in testing and diagnostic studies. The value of the MDM is often much more than what is found in the risks that the clinical conclusion presents to the patient.

Payer auditors, including Medicare contractors, have consistently argued that MDM must be determined by risks and work associated principally with the clinical conclusion, and not by the actual work to reach that conclusion or risks evaluated and ruled out in the diagnostic process. This gives them a chance to define MDM just their way.

We will work with ACEP, EDPMA and AAEM to be certain that Medicare hears clearly that patient complexity must be determined by the nature of the presenting problem and the differential diagnoses inherent in the patient's constellation of complaints.

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1. E/M Guidelines

a. Background

Most physicians and other billing practitioners bill patient visits to the PFS under a relatively generic set of codes that distinguish level of complexity, site of care, and in some cases between new or established patients. These codes are called Evaluation and Management (E/M) visit codes. For example, there are generally three levels of hospital and nursing facility inpatient E/M visit codes, and five levels of office or hospital outpatient E/M visit codes, that vary based on complexity. The latter also distinguish whether or not the patient is new to the billing practitioner.

Billing practitioners must maintain information in the medical record to document that they have reported the appropriate level of E/M visit code. CMS maintains guidelines that specify the kind of information that is required to support Medicare payment for each level. According to these documentation guidelines, there are three key components to selecting the appropriate level:

- History of Present Illness (HPI or History);
- Physical Examination (Exam); and
- Medical Decision Making (MDM).

There are two versions of the documentation guidelines, commonly referenced based on the year of their release (the “1995” and “1997” guidelines), available under downloads on the CMS Website at <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeeSched/index.html>. The most substantial differences between the two sets

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CMS-1676-P 375 of guidelines pertain to requirements for the physical exam. The two versions have a slight difference in requirements for documenting the history, and no difference in requirements for MDM. In documenting a given E/M service, practitioners must use one version of the guidelines or the other, with one exception related to extended histories (see the Evaluation and Management Services guide available on the CMS website at <https://www.cms.gov/Outreachand-Education/Medicare-Learning-Network->

[MLN/MLNProducts/Downloads/eval-mgmt-servguide- ICN006764.pdf](#)). These guidelines are very similar to guidelines within the CPT codebook for E/M visits. We provide an example of how the guidelines distinguish between level 2 and level 3 visits in Table 15.

Stakeholders have long maintained that both the 1995 and 1997 guidelines are administratively burdensome and outdated with respect to the practice of medicine, stating that they are too complex, ambiguous, and that they fail to distinguish meaningful differences among code levels. In general, we agree that there may be unnecessary burden with these guidelines and that they are potentially outdated, and believe this is especially true for the requirements for the history and the physical exam. The guidelines have not been updated to account for significant changes in technology, especially electronic health record (EHR) use, which presents challenges for data and program integrity and potential upcoding given the frequently automated selection of code level.

While CMS conducts few audits on E/M visits relative to the volume of PFS services they comprise, we have repeatedly heard from practitioners that compliance with the guidelines is a source of significant audit vulnerability and administrative burden. Our prior attempts to revise the guidelines met with a lack of stakeholder consensus and support, which contributed to

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the current policy that allows practitioners to use either the 1995 guidelines or 1997 guidelines, resulting in further complexity in determining or selecting the applicable requirements.

b. E/M Guidelines Public Comment Solicitation

We continue to agree with stakeholders that the E/M documentation guidelines should be substantially revised. We believe that a comprehensive reform of E/M documentation guidelines would require a multi-year, collaborative effort among stakeholders. We believe that revised guidelines could both reduce clinical burden and improve documentation in a way that would be more effective in clinical workflows and care coordination. We also think updated E/M guidelines coupled with technological advancements in voice recognition, natural language processing and user-centered design of EHRs could improve documentation for patient care

while also meeting requirements for billing and population health management. We recognize that achieving the goal of reduced clinician burden and improved, meaningful documentation for patient care will require both updated E/M guidelines, as well as changes in technology, clinician documentation practices and workflow. We are seeking input from a broad array of stakeholders, including patient advocates, on the specific changes we should undertake to reform the guidelines, reduce the associated burden, and better align E/M coding and documentation with the current practice of medicine. We are specifically seeking comment on how we might focus on initial changes to the guidelines for the history and physical exam because we believe documentation for these elements may be more significantly outdated, and that differences in MDM are likely the most important factors in distinctions between visits of different levels. We are also specifically seeking comment on whether it would be appropriate to remove our documentation requirements for the history and physical exam for all E/M visits at all levels. We believe medical decision-making and time are the more significant factors in distinguishing

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visit levels, and that the need for extended histories and exams is being replaced by population based screening and intervention, at least for some specialties. In addition, an increase in the utilization of EHRs, and to some extent, shared health information via EHRs, may have changed the character of extended patient histories since the guidelines were established. As long as a history and physical exam are documented and generally consistent with complexity of MDM, there may no longer be a need for us to maintain such detailed specifications for what must be performed and documented for the history and physical exam (for example, which and how many body systems are involved). We are seeking comment on whether clinicians and other stakeholders believe removing the documentation requirements for the history and physical exam would be a good approach

While we believe MDM guidelines may also need to be updated, we believe in the nearer term it may be possible to eliminate the current focus on details of history and physical exam, and allow MDM and/or time to serve as the key determinant of E/M visit level. We are seeking public comment on this approach. We are also seeking comment on how such reforms may differentially affect physicians and practitioners of different specialties, including primary care clinicians, and how we could or should account for such effects as we examine this issue. We

note, however, that there may still be clinical or legal reasons for individual practitioners to document an extended history or physical exam (for example, where there are negative findings for certain body systems in support of differential diagnosis). We are additionally seeking comment on whether CMS should leave it largely to the discretion of individual practitioners to what degree they should perform and document the history and physical exam. We also welcome comments on specific ideas that stakeholders may have on how to update MDM guidelines to foster appropriate documentation for patient care commensurate with the level of

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patient complexity, while avoiding burdensome documentation requirements and/or inappropriate upcoding.

We note that through letters, meetings, public comment letters in past rulemaking cycles, and other avenues, we have heard from many stakeholders that the E/M code set itself is outdated and needs to be revised. For example, some stakeholders recommend an extensive research effort to revise and revalue E/M services, especially physician work inputs (see 81 FR 46200). In prior rulemaking cycles, we acknowledged the limitations of the current E/M code set and agree that the structure of the underlying code set and its valuation relative to other PFS services are also important issues that we expect to continue to explore, though we are immediately focused on revision of the current E/M guidelines in order to reduce unnecessary administrative burden.

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TABLE 15: Key Component Documentation Requirements for Level 2 vs 3 Evaluation & Management (E/M) Visit

Key Component*	Level 2 (1995)	Level 3 (1995)	Level 2 (1997)	Level 3 (1997)
History (History of Present Illness or HPI)	Review of Systems (ROS) n/a	Problem Pertinent ROS: inquires about the system directly related to the problem(s) identified in the HPI	No change from 1995	No change from 1995
Physical Examination (Exam)	A limited examination of the affected body area or organ system	A limited examination of the affected body area or organ system and other symptomatic or related organ system(s)	General multi-system exam: Performance and documentation of one to five elements in one or more organ system(s) or body area(s). Single organ system exam: Performance and documentation of one to five elements	General multi-system exam: Performance and documentation of at least six elements in one or more organ system(s) or body area(s). Single organ system exam: Performance and documentation of at least six elements
Medical Decision Making (MDM) Measured by:*	Straightforward: 1. Minimal 2. Minimal or no data review 3. Minimal risk	Low complexity: 1. Limited 2. Limited data review 3. Low risk	No change from 1995	
*Two of three met or exceeded				
†For certain settings and patient types, each of these three key components must be met or exceeded (for example, new patients; initial hospital visits). For others, only two of the three key components must be met or exceeded (for example, established patients, subsequent hospital or other visits).				