July 3, 2001

Helen Blumen, MD
Medical Director
Aspen Systems Corporation
2277 Research Boulevard
Rockville, MD 20850

Dear Dr. Blumen:

The American College of Physicians–American Society of Internal Medicine (ACP–ASIM), representing the nation's largest specialty with 115,000 members, is pleased to comment on the Aspen Systems draft clinical examples that are a component of the Centers for Medicare & Medicaid Services (CMS) evaluation and management (E/M) services documentation guidelines (DGs) project.

The broad themes that we detected through our review of the internal medicine clinical examples are discussed below. Our recommendations/comments are numbered for easier reference. The worksheets containing our comments on the specific internal medicine exam and medical decision making (MDM) examples are included as an attachment to this letter.

UNDERCODING

1. Numerous internal medicine examples are undercoded, meaning that they are assigned to a lower type of exam or MDM than the documentation warrants. Undercoded exam examples are especially apparent considering that the internal medicine examples illustrate general, multi-system exams and are, therefore, governed by the actual documentation guidelines. The example project appears to demonstrate that internists are undercoding since Aspen created the examples from documentation pertaining to internists' claims that were paid as billed.

Our comments on the specific examples contained in the attached worksheets document the undercoded examples. For example, internal medicine brief exam #3 lists documentation for four body areas/organ systems: "constitutional;" "chest;" "cardiac;" and "skin." The CMS December 2000 revised DGs state that documentation pertaining to four body areas/organ systems justifies a detailed exam.

2. Even though the internal medicine examples illustrate multi-system exams and are governed under the actual DGs, ACP–ASIM believes that internal medicine exam examples can still provide helpful guidance to general internists, internal medicine subspecialists, and physicians of other specialties that perform general, multi-system exams.

OVERDOCUMENTATION

3. Numerous internal medicine exam and MDM exams are overdocumented, meaning that they contain more documentation than is necessary for on-going care of the patient, especially at the higher levels. The examples imply a documentation standard of "longer is better and shorter is brief," meaning that the quality of a chart note increases with its length and that a note short in length must indicate a brief exam or low complexity MDM. We believe that examples containing more than a physician typically documents—or needs to document—will result in unrealistic reviewer expectations. These expectations are likely to drive physicians to overdocument, resulting in voluminous medical records that contain superfluous information counter productive to optimal patient care, or put physicians at risk of having Medicare reviewers downcode their E/M service claims—even if their documentation is appropriate.

4. The majority of examples contain a disproportionate number of positive indications; notations of "normal" or "negative" are conspicuously absent. For example:

- The notation in brief exam #3 could read "chest: normal" and "cardiac: normal" as opposed to "chest: Breath sounds equal bilaterally; No wheezes, rales, or rhonchi" and "cardiac: Sounds within normal limits."

- The notation in detailed exam #2 could read: "Heart: normal" opposed to "Heart: Regular, no S_3, S_4, no gallops, rubs, murmurs."

5. The "impressions" section of the MDM examples repeat elements of history, laboratory findings, and physical exam that would be found elsewhere in the patient's medical record. We are concerned that these examples will lead Medicare reviewers to assess the complexity of MDM based solely on the information that appears as part of the impression. This review approach would compel physicians to unnecessarily re-document information in the patient's records or risk having the claim downcoded. Reviewers must be required to evaluate complexity of MDM using all relevant portions of the medical record.

Additional comments on the specific examples contained in the attached worksheets reference the overdocumented examples.

CONTEXT

6. The examples fail to provide context by omitting pertinent information such as patient age, presenting problem, and history. Each example should have a heading briefly stating the presenting problem, e.g. "78 year old male; underlying DM, HTN; presents with failure to thrive, cough, CXR shows large lung mass."

7. The examples fail to specify the E/M service code, or even the type of E/M service, for which the documentation pertains. Each example should indicate the E/M service to which the documentation pertains. The examples currently fail to distinguish a new patient from an established patient, an office visit from an office consultation, etc. This is important as it can help the Medicare reviewer (and the physician) decipher the complexity of MDM, e.g. the

decision-making process is typically more complex for a consultation opposed to an established patient office visit.

SAMPLE SIZE

8. ACP–ASIM recognizes that a number of example deficiencies are likely the result of Aspen using/having access to an inadequate sample size of medical record documentation from which to draw examples.

9. The internal medicine examples pertain primarily to acutely sick patients and, therefore, are overly complex. They focus primarily on acute clinical situations and fail to adequately account for internists' assessment and management of chronic conditions. High Complexity MDM examples pertain exclusively to life-threatening conditions, such as cancer and conditions requiring hospital admissions.

It is insufficient to use examples to conduct medical review without maintaining an internal medicine example(s) illustrating high complexity MDM in the outpatient setting. Internists often perform outpatient visits that involve high complexity MDM. Medicare Part B utilization data for 1998 shows that internists bill approximately twice as many established patient office visits, approximately 42 million as initial and established patient hospital visits, approximately, 23 million.

10. The internal medicine examples fail to illustrate the provision of psychosocial care. Internists often care for patients with mental health-related conditions, the most common being anxiety disorders and depression. Internists treat these conditions during the course of a medical visit or as the primary reason for the encounter. Examples illustrating psychosocial care are preferred even though physicians can select the level of E/M service based on the time spent with the patient when counseling and/or coordination of care dominates the encounter. Internists' discussion of these issues with patients is often intermingled with other medical issues and is difficult to tease out.

Further, the examples fail to recognize many other common issues faced by internists in caring for an adult and often geriatric population. Examples of these issues are:

- Dementia
- Weight loss
- Falls
- Pain

11. The examples fail to capture continuous care that occurs between patient visits. It would be helpful if examples illustrated on-going care handled via telephone, mail, and/or electronic communication. Examples should contain documentation of physician review of patient data and the corresponding change in treatment plan that results from non face-to-face interactions. This is necessary as Medicare considers these services to be bundled into the payment for the E/M service generated by the face-to-face encounter. These services can influence the

physician's selection of a level of E/M service, if documented, as Medicare will not pay separately for them. For example, an internist may contact a patient by phone to communicate a change in treatment plan based on a prothrombin time test result. The frequency of these valuable communications will increase in the future as advances in technology allow physicians to provide medical care with fewer face-to-face patient encounters.

12. The sample size problem affects specialties beyond internal medicine. We are aware that some specialties observed that examples illustrating exam and MDM for patient conditions that they most often encounter are lacking. For example, ophthalmology stated that none of its examples pertain to an encounter with a patient presenting with glaucoma.

BODY AREAS AND ORGAN SYSTEMS

13. It is our understanding that Aspen attempted to list findings in the exam examples using body areas exclusively. The internal medicine exam examples contain a combination of body areas and organ systems. For example, comprehensive exam #1 includes a notation for organ system "cardiac" and "neurological." Notations for the "cardiac" organ system appear throughout the exam examples. ACP–ASIM recommends that Aspen urge CMS to work with the AMA CPT Editorial Panel to clarify body areas and organ systems, exploring the possibility of creating a single list. The lack of a clear distinction between body areas and organ systems has implications for reviewers when assessing documentation pertaining to single system exams as well to general multi-system exams.

ABBREVIATIONS

14. Aspen should spell out any non-standard abbreviation. We noted a few abbreviations that may not be universally recognized by the physician community. For example, high complexity MDM #2 uses the abbreviation "PCU." We believe it stands for "patient care unit" but question whether it is widely understood.

CMS USE OF EXAMPLES/FUTURE STEPS

15. Aspen has indicated that it intends to conduct a second specialty comment period, after it revises examples based on the first round of comments, that will ask specialties to focus on cross-specialty work equivalency. Since reviewing all examples for the 17 specialties will be a resource-intensive effort, we recommend that Aspen:

- Combine all first-round specialty comments into a single document and make it available to commenters;

- Convene a meeting to summarize the first-round specialty comments and explain the changes it made (and declined to make) to the examples; and

- Urge CMS to convene a meeting to explain exactly how it intends to use the examples. ACP–ASIM has reservations about devoting further resources to example review when CMS has yet to adequately detail how Medicare reviewers will use the examples and, thus, how physicians will use the examples. ACP–ASIM and other specialties cannot make an informed decision regarding the cost-benefit of further participation until CMS clarifies its intent. We suggest that CMS use such a meeting to simulate how a review will be conducted under its planned policy implementing examples into the review process and using the actual Aspen-developed examples. To illustrate, a Medicare-qualified reviewer (physician or registered nurse) would walk through the review of the documentation provided by a gastroenterologist for an established patient office visit using the gastroenterology examples. This same process would be followed for claims pertaining to a number of specialties for which Aspen has created examples. We believe that clarification from CMS will help Aspen fulfill its contractual obligations as we understand them.

POTENTIAL ALTERNATIVE APPROACH

16. The internal medicine examples are not constructed in a way that is educational even though it is our understanding that examples are to help physicians understand appropriate documentation and select a level of E/M service. An alternative, more educational approach, would be to take the ten most prevalent disease states per specialty, including functional diseases, and illustrate documentation for the same patient pertaining to a level 2, 3, 4, and 5 depending on the presentation. This would enable physicians to follow documentation differences in a logical manner.

Moderate complexity MDM example #7 can be used to illustrate this approach. The example contains documentation for a cancer patient presenting with clinical dehydration. It is listed as a moderate complexity MDM example. The MDM would become highly complex if the patient was suffering from a serious condition, such as sepsis. A physician could diagnose such a condition by checking the patient's blood pressure and other vital signs. This example could be used as a foundation to demonstrate how complexity can increase (or decrease) depending on the approach the physician takes to diagnosis and treat the patient. Illustrating the range of complexity by expanding on the basic presenting problem may be a better way to clearly distinguish appropriate documentation and levels of E/M services.

ACP–ASIM appreciates the opportunity to comment on the Aspen clinical examples. Please contact Brett Baker, Senior Associate, Regulatory Affairs, by phone at (202) 261-4533 or by e-mail at bbaker@mail.acponline.org if you have questions.

Sincerely,

C. Anderson Hedberg, MD, FACP
Chair, Medical Services Committee

Attachments

American College of Physicians–American Society of Internal Medicine

Evaluation and Management Documentation Guidelines (EMDGs) Clinical Example Review Worksheet

Brief Physical Examination

Clinical Example	Please check one (√):			Suggested Revisions *Please include line numbers
	Useful as is	Useful with suggested revisions	Not useful	
1		**X**		This is a detailed exam. "Mild discharge in left eye" pertains to ophthalmologic organ system and "no blurry vision" pertains to the neurologic organ system. Accordingly, the exam address four body area/organ systems: constitutional, HEENT, ophthalmologic, and neurologic.
2	**X**			
3		**X**		This is a detailed exam as it involves four body areas/organ systems: constitutional, chest, cardiac, and skin. Also, inclusion of respirations makes it likely that the history includes an infection. The rash may or may not be related to the infection so the physician needs to assess two possibly unrelated conditions.
4		**X**		This a detailed physical exam as it involves four body areas/organ systems: constitutional; chest; pharynx; and cardiac.
5		**X**		This is a detailed exam as it involves five body areas/organ systems. The "other" category contains documentation pertaining to two additional organ systems: "no lymphadenopathy" pertains to the hematologic/lymphatic organ system and "[no] hepatosplenomegaly" pertains to the abdominal body area or gastrointestinal organ system. Change "rhythmic" to "regular rhythm, no murmur."

				It is unclear which body area/organ system pertains to the presenting problem. This example illustrates the need for a heading that describes the presenting problem. [see accompanying ACP–ASIM letter]
6	**X**			
7	**X**			
8	**X**			

Additional Comments:

Evaluation and Management Documentation Guidelines (EMDGs)
Clinical Example Review Worksheet
Detailed Physical Examination

Clinical Example	Please check one (√):			Suggested Revisions *Please include line numbers
	Useful as is	Useful with suggested revisions	Not useful	
1		**X**		This is comprehensive exam as it involves nine body areas/organ systems: constitutional; HEENT; neck; cardiac; chest; abdomen; extremities—right lower extremity AND left lower extremity; and neurologic.
2		**X**		This could be a comprehensive exam. Notation indicating "encephalopathic" pertains to neurologic organ system. Constitutional can still count as an body area/organ system since three vital sign/general appearance findings remain after encephalopathic is removed and counted as neurologic. "Alert" and "encephalopathic" is not congruent.
3		**X**		This is a comprehensive exam as it involves more than eight body areas/organ systems. "TMs normal" in the HEENT section pertains to the back body area; "thyroid" in neck section pertains to the endocrine organ system; and "surgical scars over knees" in the extremities section pertains to the skin body area. Also, exam of "hands" in the extremity section can be interpreted as two body areas.
4	**X**			
5		**X**		This is a comprehensive exam. "Adenopathy" in the neck section pertains to the hematologic/lymphatic organ system; "thyromegaly" in the neck section pertains to the endocrine organ system. Accordingly, the exam involves at least 10 body areas/organ systems.
6		**X**		This is a comprehensive exam, especially if

				exam of multiple extremities count as more than one body area.
7	**X**			
8	**X**			

Additional Comments:

The distinction between body areas and organ systems is ambiguous. CMS needs to clarify how Medicare reviewers will count body areas/organ systems, e.g. does exam of both arms and legs count as four body areas or is it a single body area. A clarification would be relevant to single system exams as well as to general, multi-system exams. See accompanying ACP–ASIM letter for more information.

Evaluation and Management Documentation Guidelines (EMDGs)
Clinical Example Review Worksheet
Comprehensive Physical Examination

Clinical Example	Please check one (√):			Suggested Revisions *Please include line numbers
	Useful as is	Useful with suggested revisions	Not useful	
1	X			
2	X			
3	X			
4	X			
5	X			
6	X			
7	X			
8	X			

Additional Comments:

The comprehensive exam examples are overdocumented, meaning that they contain more documentation than is necessary for on-going patient care. Aspen should consider editing the documentation to avoid creating unrealistic Medicare reviewer expectations. See accompanying ACP–ASIM letter for more information.

Evaluation and Management Documentation Guidelines (EMDGs)
Clinical Example Review Worksheet
Low Complexity Medical Decision Making

Clinical Example	Please check one (√):			Suggested Revisions *Please include line numbers
	Useful As is	Useful with suggested revisions	Not useful	
1		**X**		This is moderate complexity medical decision making as it involves three chronic problems, one more actively managed than the others. It involves anticoagulant management, which often requires complex decision making.
2			**X**	This is high complexity medical decision making because the patient is at risk of drug toxicity, the potential is indicated by the notation that the hypertension is "possibly due to quinine." The fact that this is a new problem further supports that the medical decision making is high complexity.
3		**X**		This is at least moderate complexity medical decision making as the patient has five different conditions. It is unclear which conditions are actively being treated and which are stable. It is also unclear how many medications the patient is taking. Line 9: We question the notation: "GI Bleed stable." While a GI bleed could be stabilized in the inpatient setting. The documentation appears to pertain to an office visit. It is unlikely that the patient has a history of a GI bleed.
4		**X**		This is at least moderate complexity medical decision making. The notation of "recurrent angina" indicates that the problem is persistent and that the patient is not responding to drugs. Recurrent angina could indicate a life-threatening situation. Stress test indicates high risk. A negative thallium test means that several things must be considered in differential diagnosis.

5		**X**		This is moderate complexity medical decision making as the patient has two conditions that have the potential to be life threatening. An adverse drug reaction is a potential third problem. TIA and consideration of endarterectomy and risk for a stroke further indicates moderate complexity.
6		**X**		This is likely moderate complexity medical decision making as it appears that the patient has one acute problem and two chronic conditions and multiple medications. It is moderate complexity if the documentation pertains to a new patient visit and/or a new diagnosis.
7		**X**		We assume the patient has one acute problem and three stable conditions. It could be moderate complexity if there is significant amount of history detail regarding the stable conditions. You cannot tell without the history or better diagnostic descriptors what is chronic, acute, exacerbation of acute etc. This is a good example of why you cannot assess the decision making complexity without the history.
8				

Additional Comments:

Evaluation and Management Documentation Guidelines (EMDGs)
Clinical Example Review Worksheet
Moderate Complexity Medical Decision Making

Clinical Example	Please check one (√):			Suggested Revisions *Please include line numbers
	Useful as is	Useful with suggested revisions	Not useful	
1		**X**		This is high complexity medical decision making. The patient has eight problems and could potentially be suffering from acute renal failure.
2		**X**		This is high complexity medical decision making. The patient has five problems, including drug toxicity; deciding to order a dental extraction for a patient on Coumadin involves complex decision making.
3	**X**			This is moderate complexity if renal insufficiency is an old problem. It is difficult to judge the severity of the patient's illness as the example does not offer recent lab results.
4		**X**		This is high complexity medical decision making as it involves planning invasive surgery for a high-risk patient. The physician had to evaluate the high risk of no surgery against the high risk of surgery. Impression #2, i.e. "lower chest discomfort…" indicates a possible myocardial infarction.
5	**X**			
6			**X**	This examples appears to illustrate an atypical case as the patient has bilateral pneumonia and a near normal WBC. The documentation illustrates moderate complexity decision making. However, the care plan implies that the patient is seriously ill and may indicate high complexity decision making. Line 16: We are unsure that the abbreviation "IVPB" is universally recognized. Does it mean IV push bolus?

7		**X**		This is high complexity because of differential diagnosis of abdominal pain, high severity in a patient with dehydration and breast cancer.
8	**X**			

Additional Comments:

Evaluation and Management Documentation Guidelines (EMDGs)
Clinical Example Review Worksheet
High Complexity Medical Decision Making

Clinical Example	Please check one (√):			Suggested Revisions *Please include line numbers
	Useful as is	Useful with suggested revisions	Not useful	
1		**X**		This high complexity medical decision making example boarders on critical care (if time were documented).
2		**X**		This high complexity medical decision making example boarders on critical care (if time were documented). Line 7: We are unsure that the abbreviation "PCU" is universally recognized
3		**X**		This is high complexity medical decision making if the documentation pertains to a new patient and/or a consultation. However, it is moderate complexity if the patient has been worked up over months, meaning that much of the information is already known.
4		**X**		Line 25: The ejection fraction seems off: if the EF is 50's then there is no left ventricular dysfunction or should the EF be in the 30s or 40s.
5		**X**		We agree that this example illustrates high complexity medical decision making. We note that the example describes a very complex patient; it would be high complexity even if it described one of the patient's problems.
6		**X**		This high complexity medical decision making example boarders on critical care (if time were documented).
7		**X**		This high complexity medical decision making example boarders on critical care (if time were documented).

8	**X**			

Additional Comments:
We believe that the high complexity medical decision making examples describe very complex patients, some examples would likely warrant a bill for critical care if the time the physician spent with the patient was documented. We are concerned that these "overdocumented" examples may result in unrealistic Medicare reviewer expectations; that reviewers will only assign high complexity medical decision making to the most extreme situations. This is the reason we put an "X" in the "useful with suggested revisions" column.