STATEMENT OF THE ACP-ASIM WORKING GROUP
ON
EVALUATION AND MANAGEMENT (E/M) DOCUMENTATION GUIDELINES
March 19, 1998

PURPOSE

The purpose of the statement is to: (1) describe the issues surrounding the evaluation and management (E/M) documentation guidelines discussed by the American College of Physicians (ACP)-American Society of Internal Medicine (ASIM) working group; (2) list the ACP-ASIM working group recommendations on strategy regarding the use of the guidelines by the Department of Health and Human Services; and (3) list the ACP-ASIM working group recommendations on the structure and content of the guidelines for the American Medical Association CPT Editorial Panel.

BACKGROUND

Physicians’ Concern With the E/M Documentation Guidelines

No issue in our recent experience has aroused a greater outcry from physicians than documentation guidelines for evaluation and management services. ACP and ASIM have been inundated with correspondence from physicians urging us to seek revision and simplification of the guidelines.

First and foremost, we are concerned that the documentation guidelines, as they are currently constituted, will cause patient care to suffer. The guidelines put an undue excessive documentation burden on physicians for the sole purpose of billing, not for quality medical care. These guidelines will force physicians to spend less time with their patients and more time with the patients’ charts. The guidelines detract the physician’s attention from patient care and medical decision-making.

The administrative complexity and cost of providing care to Medicare patients is a serious issue for many physicians. When one internist learned of the new guidelines, he began to question whether “billing decision making” is becoming harder than medical decision making.

In an effort to answer this question, one of our members carefully reviewed the new documentation requirements and calculated the number of decisions that one must make prior to billing Medicare for E/M services. There are eleven decision points or categories that must be considered before selecting an E/M code. A number of choices must be made at each decision point. For example, is the history of the present illness (HPI) brief or extended? Two choices must be considered when deciding on the extent of the HPI. Examining each subsection of the guidelines, it was determined that there are 42 choices one must consider before selecting the proper level of E/M service. If you omit the values for the overall history, overall physical and overall medical decision making, the number of possible combinations representing the number of ways an office visit for a new patient could evolve and be classified by this documentation system is 6,144 possible different combinations. Reporting the proper E/M code is so complicated under the new guidelines that physicians are at risk of making inadvertent coding errors.

As one of our members writes, “the guidelines are in many ways contrary to realistic good medical practice.”

Organized Medicine’s Response to the Problem

The American Medical Association (AMA) House of Delegates (HoD) passed an ASIM resolution, supported by ACP, calling on the AMA to look at ways to reduce excessive documentation requirements at its June 1997 meeting. This position was reaffirmed by the AMA HoD in December 1997.
specialty societies interested in changing the guidelines must submit their proposals to the AMA by March 15, 1998. AMA will review these proposals before its leadership meets with Health Care Financing Administration (HCFA) in late March to have a preliminary discussion about refining the guidelines. AMA will then convene a meeting of its Current Procedural Terminology (CPT) Editorial Panel, medical organization leaders, and HCFA officials in Chicago on April 27, 1998 to discuss specific proposals for revising the documentation guidelines. The ACP-ASIM working group recommendations to the AMA CPT Editorial Panel contained in this statement will be submitted to the AMA for their consideration at the April 27, 1998 meeting. The CPT Editorial Panel is also scheduled to discuss the documentation guidelines at its May 1998 meeting and, if necessary, at its August 1998 meeting. At a meeting of the National Committee on Vital Health Statistics last week, AMA officials indicated that they were seeking “any and all suggestions to revise the documentation guidelines.”

HCFA officials recently told ASIM that it will most likely accept all changes made by the AMA CPT Editorial Panel. HCFA believes that the AMA will not publish the evaluation and management documentation guidelines in CPT ’99. Also, HCFA anticipates that the guidelines will be updated yearly through the AMA CPT Editorial Panel process. So, if additional concerns remain regarding the content of the documentation guidelines after this upcoming round of revisions there should be additional opportunities to revise the guidelines through the CPT process.

The revised documentation guidelines took effect October 1, 1997. HCFA originally announced that physicians would be given a three-month “grace period,” meaning that they would be able to use the either the old or the revised guidelines until December 31, 1997. Expressing concern that the grace period was insufficient to properly educate physicians on the content and use of the new guidelines, AMA persuaded HCFA to extend the grace period until June 30, 1998. AMA will ask HCFA to extend the grace period further so it can consider changes to the guidelines and to continue its educational efforts. HCFA officials advised ASIM that the agency is likely to extend the grace period until October 1, 1998 or January 1, 1999.

At this time, the working group believes that the best recourse for revising the documentation guidelines is through the revision process developed by the AMA. The working group recognizes the importance of keeping the development of such guidelines within the realm of organized medicine to ensure that physicians have adequate opportunity to be involved in the development process. The working group does not want HCFA to develop guidelines and audit criteria independently of organized medicine. If the working group is dissatisfied with progress made in revising the documentation guidelines then direct action with HCFA may be necessary.

INCORPORATION OF THE GUIDELINES INTO MEDICAL REVIEW

Medicare carriers are currently using both the original and revised guidelines in prepayment medical review and in post payment medical review audits. Carriers deny payment for an E/M service claim if a prepayment review determines that the documentation fails to justify the level of service billed. Carriers request a refund from physicians if a post payment medical review audit reveals inadequate documentation to justify the level of service billed.

The working group believes that HCFA can best encourage physicians to document and code correctly--helping to ensure that Medicare pays for each E/M service appropriately--by implementing the soon-to-be revised guidelines in an educational manner. The guidelines should be used to review only physicians whose utilization (patterns of care) indicates that they are outliers. If a physician’s documentation does not comply with the guidelines, the physician should be advised of this and be offered educational assistance on how to document better, but no claims would be denied based on an initial review. If the revised documentation requirements are used in this manner claims would be denied only in cases where a physician engaged in a pattern of coding that was identified as being a statistical outlier; the physicians’ documentation was subsequently reviewed by the carrier and found to be inadequate; and the physician subsequently failed to take corrective actions and continued to engage in a pattern of billing that was not supported by the documentation.
Given all of the emphasis that Congress and the administration are placing on reducing "waste, fraud and abuse" in the Medicare program, it is unlikely that HCFA will limit carriers’ authority to recoup overpayments that are discovered during an initial post-payment utilization review, however. In such instances, internists may be required to reimburse Medicare for the overpayments, plus interest, which can run into tens of thousand of dollars. Very few of such instances of overpayment will meet the statutory requirements to trigger a fraud and abuse investigation, however, despite widespread concern by internists that this will be the effect of the new documentation guidelines.

The fraud and abuse law, as amended by the Health Insurance Portability and Accountability Act of 1996 (HIPAA), states that physicians and other providers can be sanctioned for program abuse (covering such things as upcoding and billing for medically unnecessary services) under the civil monetary penalties of the statute only to the extent that the person "acts in deliberate ignorance of the truth or falsity of the information or acts in reckless disregard of the truth." Fraudulent activities that carry with them criminal penalties require that the person was "knowingly and willfully executing, or attempting to execute, a scheme or artifice to defraud any health care benefit program, or to obtain by false pretenses any money or property under the custody of a health care benefit program."

Further, report language from the House and Senate conference committee that developed the final language of the HIPAA states that Congress does "not intend to penalize the exercise of medical judgment of health care treatment choices made in good faith, and which are supported by significant medical evidence or held by a respectable minority of those providers who customarily provide the service. The Act is not intended to penalize providers simply because of a professional difference of opinion regarding diagnosis and treatment. A sanction is not intended for providers who submit claims they know will not be reimbursed as medically necessary services, but who are required to submit the claims because beneficiaries need to document that Medicare will not reimburse of a service." The report language is important, because the courts will look to such language for guidance on congressional intent whenever the meaning of the statute itself is not clear.

Therefore, a physician whose documentation fails to support the level of service submitted for an E/M service code is not guilty of fraud or abuse, unless he or she acted "in deliberate ignorance" or "reckless disregard" of the truth. Submitting a claim for a service that is later found to be medically unnecessary also doesn't constitute fraud or abuse without evidence of a deliberate or reckless disregard of the truth or a knowing and willful intent to defraud the program.

In egregious situations where a physician consistently refuses to improve documentation and coding practices--after being advised by a carrier that there is a problem--the Department of Health and Human Service Office of Inspector General (OIG) may be called in to determine if the physician has engaged in "reckless disregard" or "deliberate ignorance" of the truth, which by law could be grounds for civil monetary penalties. The working group is concerned that the OIG may overstep their authority and begin auditing physician practices without proving that physicians have acted in reckless disregard or deliberate ignorance of the truth. The OIG can impose civil penalties that are so severe--$10,000 per service, with a maximum of three times the amount that was falsely claimed, plus a possible five year exclusion from the Medicare and Medicaid programs--that most physicians would likely settle with the OIG rather than risk going to court. Therefore, physicians could be pressured into entering into a costly settlement with the OIG, even though the OIG might have difficulty proving in court that the physicians' billing patterns constituted abuse or fraud.

The AMA has indicated that it intends to use regulatory, and if necessary legislative, channels to ensure that the federal government does not unfairly target physicians for investigation for fraud and abuse due to inadvertent coding errors that do not meet the law's definition of fraud and abuse. The working group will monitor these developments.

The working group recommends that the Medicare program institute its medical review procedures in the following manner:
HCFA and other auditors should recognize that any HCFA/AMA documentation guidelines are not sole coding standards, but can be used as a guide. Auditors should also recognize alternative coding guides as they are made available.

The new documentation guidelines for E/M services should initially be used as an educational tool to assist physicians to better document their E/M services. The documentation guidelines should not be used in a punitive fashion by carriers, the OIG, or other auditors during an initial review of the physician's claims. Instead, auditors should provide education and feedback to the provider to assist the provider in improving his/her documentation.

Claims denial and/or fraud and abuse investigations should only be evoked when a physician failed to improve his or her documentation or when there is an reasonable cause to suspect fraud or abuse.

The new documentation guidelines for E/M services must be open to annual improvement--allowing medical societies to suggest guideline changes to the CPT Editorial Panel for acceptance. The use of the new documentation guidelines cannot be retroactively applied to audits of medical records for services rendered prior to the full implementation of the new guidelines.

HCFA should increase its educational activities regarding the content and use of the new documentation guidelines by ensuring that its carriers send each physician who provides services to Medicare patients a copy of the guidelines. Physicians must be made aware that the guidelines exist and medical societies should not be primary organizations saddled with this educational responsibility.

HCFA should use the information it obtains from medical review of documentation for E/M claims to provide general educational feedback to the physician community on the appropriate use of the new documentation guidelines to physicians for a specified period of time of at least six months before denying payment for claims.

HCFA should only use the documentation guidelines to review those physicians whose utilization (patterns of care) indicates that they are outliers. For example, a carrier would first have to identify, based on statistical profiles that recognize severity of patient case-mix, that a physician has an unusual pattern of utilization of the E/M codes; for such “outlier” physicians, the carrier could request documentation and compare them with the guidelines. If the physician’s documentation does not comply with the guidelines, the physician should be advised of this and be offered educational assistance on how to document better, but no claims would be denied based on this initial review.

The OIG should clearly inform the medical community how they plan to use the documentation guidelines in their review process.

The OIG should work with the medical community--including national medical specialty societies--to develop a model compliance plan using HCFA data gathered from medical review activities to further educate physicians on properly documenting evaluation and management services.

HCFA and the OIG should acknowledge that inadvertent coding errors and inadequate documentation do not constitute fraud or abuse.

HCFA and the OIG should refrain from counting billing errors or inadequate documentation in fraud and abuse estimates, and be careful not to impose sanctions on
providers who simply commit honest mistakes and not engaging in fraudulent or abusive behavior.

12. HCFA and AMA should educate physicians more about the legitimate use of time as a factor in documenting their services.

13. If billing entities not under the direct employment of the physician (e.g. billing companies, medical services organizations, physician hospital organizations, etc.), recode physician-submitted encounter forms, or by policy do coding in lieu of physicians, the physician should not be the target of fraud and abuse investigations or sanctioned for acts or errors not under the physician’s control.

14. HCFA and the OIG should work with the AMA, and physician specialty societies, in an open process to draft, adopt and regularly revise, any audit tools and algorithms, as well as teaching programs to educate personnel who will conduct audits for carriers or federal agencies, as these tools, algorithms and related materials should be publicly disclosed and available for an adequate period of notice and comment before they are applied.

15. In order to ensure that the documentation guidelines are properly implemented and utilized by HCFA and the OIG this process should be monitored by the appropriate independent government agency, such as the U.S. General Accounting Office.

RECOMMENDATIONS ON THE STRUCTURE AND CONTENT OF THE GUIDELINES

The ACP-ASIM working group agrees with the concept of documentation guidelines to promote consistency in medical review of claims and to prevent arbitrary downcoding by carriers, but the present guidelines are too onerous and need to be streamlined. The working group believes that complying with the comprehensive and complex guidelines will force physicians to become preoccupied with meeting the guidelines to justify payment—detracting from the time they have available to actually treat patients.

The ACP-ASIM working group’s recommendations should ensure that the evaluation and management documentation guidelines strike an appropriate balance between the practicing physician’s documentation to provide good medical care and carriers need to verify documentation to justify payment for services rendered in an audit.

General Recommendations

The working group recommends that:

1. Before the revised guidelines are adopted by the AMA CPT Editorial Panel the guidelines should be pilot tested nationally.

Clearly, the current documentation guidelines have presented problems for practicing physicians. To avoid making the same mistake again, the working group recommends that pilot testing be done. Pilot testing should not unduly hold up the process to simplify the guidelines however. When the E/M service codes were developed, there was substantial pilot testing under actual practice conditions. The changes contemplated by these documentation requirements are of similar magnitude; therefore, pilot testing should be conducted here as well, along with an evaluation of the impact on quality and cost.

2. An economic analysis (e.g., one which considers the time devoted to fulfilling the documentation requirements rather than providing patient care) should be performed to study the impact of these guidelines.
To date, no one has undertaken any study of this important aspect of the guidelines and their impact on the cost of health care.


The guidelines on new versus established patient documentation requirements for problem-focused social history (PFSH) are contradictory to CPT. The guidelines state the following for the complete PFSH: “A review of all three history areas is required for services that by their nature include a comprehensive assessment or reassessment of the patient. A review of two of the three history areas is sufficient for other services.” According to CPT, a comprehensive history is required with a level 5 established office visit. However, this contradicts the documentation guidelines for PFSH which state that a review of 2 out of 3 history areas is required for an established patient office visit. Physicians are uncertain whether the 3 out of 3 requirement or 2 out of 3 requirement applies here. Either the guidelines need to be further refined and examined in conjunction with proper CPT coding or a hierarchy must be established that recognizes that the CPT Coding Manual takes precedence over the E/M documentation guidelines.

Examination Section

The working group offers the following recommendations to reduce the documentation burden of the examination section of the guidelines:

1. The system/body area-elements of the examination section be eliminated and that this portion of the guidelines revert back to their 1994 form, until such time that the following recommendation can be pilot tested and implemented with an adequate educational time period.

2. Entire body systems within the system/body area-elements of examination section should be allowed to be described as “normal” if the elements within that body system are indeed normal. Only those body system elements (bullets) that are pertinent positives and negatives would then need to be specifically identified and documented.

History Section

The working group offers the following recommendations to reduce the documentation burden of the history section of the guidelines:

1. The documentation guidelines should specify that auditors will not reduce the level of service billed because a history was unable to be obtained from a patient because the patient was non-compliant or unable to provide a history due to some extenuating circumstance.

2. Rather than requiring 1 to 3 history of present illness (HPI) elements and no past, family and/or social history (PFSH) items for a problem focused and expanded problem focused history, we recommend that no HPI or PFSH element be required for a problem focused history, but that at least one HPI and PFSH be required for a expanded problem focused history.

3. Where the HPI requires 1 to 3 HPI elements, they should be able to be substituted by the status of 1-2 chronic or clinically pertinent but inactive conditions. Similarly, where the history guidelines require 3 chronic conditions, clinically pertinent but inactive conditions should be allowed as well.
4. As an alternative to the review of systems (ROS) history section, the AMA should consider using descriptions of clinically pertinent of functional status items, such as: feeds self, dresses self, able to do own shopping, etc. Functional status is commonly more pertinent to the patient’s history, especially for geriatric patients.

5. There should be 4 levels of PFSH (--, 0,1,2,3) for the problem focused, expanded problem focused, detailed and comprehensive levels of history.

Complexity of Medical Decision Making Section

Determining complexity of medical decision making using the current guidelines is simply beyond the capabilities of most non-physician fee abstractors and chart auditors. Unless progress notes are embellished with excessive, redundant and often irrelevant prose targeted at lay people, the people who translate notes into CPT codes cannot reliably distinguish sick, complex patients from those who are not. For many physicians, this is a continuing source of friction and discord within their practices. The working group recognizes that this section of the guidelines is critically important to justifying the selection of the proper E/M code level and therefore recommends:

1. that the complexity of medical decision-making guidelines be throughly reviewed and recommendations offered before implementation of this section of the guidelines.
SINGLE ORGAN SYSTEM EXAMS

The working group focused on the general multi-system exam and decided to leave comments on revising the eleven single organ-system exams--identified below--to the specialty societies.

- Cardiovascular
- Genitourinary (male)
- Genitourinary (female)
- Hematologic/Lymphatic/Immunologic
- Neurological
- Respiratory
- Ears, Nose, Mouth, Throat
- Eyes
- Musculoskeletal
- Psychiatric
- Skin

The working group will monitor recommendations on the single organ-system exams and will comment as necessary.