The American College of Physicians–American Society of Internal Medicine (ACP–ASIM), representing over 115,000 members, is pleased to provide testimony to the Practicing Physicians Advisory Council (PPAC) regarding Physician Participation in Evaluation and Management (E/M) Guidelines Pilot Studies and Contractor Oversight Issues.

**PHYSICIAN PARTICIPATION IN EVALUATION AND MANAGEMENT GUIDELINES PILOT STUDIES**

*How to Address Issues of Miscoding and Medical Review in Studies*

**Recommended Pilot Projects**

**Encounter Time**

ACP-ASIM recommends that the Centers for Medicare & Medicaid Services (CMS) conduct a pilot test that allows physicians to select a level of E/M service based on encounter time with the patient with documentation of the E/M documentation “basics” as defined in the “general principles of medical record documentation” section of the guidelines. Current Procedural Terminology (CPT) currently states that physicians can use time to select a level of service when patient counseling and/or coordination of care accounts for more than 50% of the encounter. The concept could be expanded to give physicians the option to use time to select a level of service for all E/M services. The concept could be pilot-tested for documentation purposes without changing the actual CPT descriptors. The AMA CPT Editorial Panel could consider incorporating the expanded role of time if the pilot was successful.

Comments made by CMS and others lead us to believe that our proposal is still not clearly understood. Physicians would have the option to select a level of service by comparing the length of the encounter to the “typical times” found in CPT or according to the traditional method using extent of history, exam, and decision making. The proposal would not penalize physician efficiency nor would it require CMS to pay more in the aggregate for E/M services. Physicians have a financial disincentive to extend the length of a service simply to bill a higher level of service. A physician would generate more revenue by furnishing and billing for more frequent lower level services.

We believe it would be relatively inexpensive for CMS to pilot test a time-based approach. It would be unnecessary for CMS to send individuals or instruments to monitor the precise length of services. CMS could use the same audit process it plans for its other pilot tests. Our proposal requires physicians to document relevant clinical information beyond the length of the
encounter. Plus, CMS could ask for the charts pertaining to all the services the physician performed in a given day if the reviewer suspected that the physician was misrepresenting the time he or she was spending with patients. Carriers may also be able to detect potential coding abnormalities by looking at physician billing profiles.

Our research indicates that physicians who select the level of E/M service themselves typically consider face-to-face patient encounter time as a surrogate for physician work. Moreover, the Harvard Hsaio study and a Physician Payment Review Commission (PPRC) study demonstrated a very tight statistical correlation between the assessment of physician work and the intra-service time associated with providing an E/M service. Our proposal is consistent with CPT structure as it allows physicians to cite time as a proxy for the work performed (i.e. history, exam and decision making).

Further, CMS should provide an update on the status of its comprehensive review of the encounter time contained in National Ambulatory Medicare Care Survey (NAMCS) data. At the October 2000 AMA Relative-value Scale Update Committee (RUC) meeting, CMS stated that the NAMCS data showed a strong correlation between encounter time and work for internal medicine E/M services. While this statement seems to support our encounter time proposal, CMS stated that it is working on a more comprehensive analysis of the NAMCS data.

CMS should take advantage of this opportunity to test an idea that would simplify documentation requirements while ensuring that physicians report a level of service consistent with the work and effort involved in providing the service.

**Outlier Approach**

ACP-ASIM commends CMS for agreeing to design a pilot program to determine whether the outcomes of medical review determinations are substantially different when performed by specialty physician reviewers as compared to the current system employing nurse reviewers. We are pleased that CMS intends to work with the California Medical Association (CMA) to design the program since the CMA has been the primary advocate for this peer review approach.

**CMS should incorporate the CMA outlier approach into its pilot test(s).** At a minimum, however, physician reviewers should participate in first level review of at least a portion of the pilot claims. We encourage CMS to use the CMA outlier approach pilot to determine if it can verify that it is paying appropriately without prescriptive documentation guidelines. The medical record must continue to primarily serve as a tool for clinical care. CMS must do everything possible to ensure that it refrains from turning the medical record into an accounting document. Pilot testing an outlier approach is a reasonable step toward achieving that goal.

**Capturing Documentation Time Necessary to Adhere to Documentation Guidelines**

**All CMS-selected pilot tests should include a mechanism for assessing the amount of physician time and work involved in adhering to the documentation guidelines.** A potential mechanism would be for CMS to request the information through questions such as:
• Did documentation of this encounter using 2000 draft documentation guidelines require more, less, or the same time as documenting utilizing the 1995 and/or 1997 documentation guidelines?

More _____ Less _____ Same _____ If more or less, by what percent in your estimate? ____% more or less.

• How much time did it take you to document this service?
  _____ minutes

• If you weren’t expected to utilize published documentation guidelines, would your chart documentation have taken:

  More time _____ Same time _____ Less time _____

We are open to other ways to collect information regarding the amount of time it takes to comply with the documentation guidelines and are willing to work with CMS to explore possibilities. Information should be collected in a way that minimizes the burden to physicians but in a way that CMS can reasonably verify its accuracy.

**Proposed Pilot Study Specifications**

**Length**

**ACP–ASIM recommends that CMS allow nine months for pilot testing.** Allotting nine months would provide insulation against the problems that are likely to result from implementation of systems that are new to all involved.

**Records Reviewed**

We agree that it is reasonable to request records pertaining to 30 E/M claims from each physician who participates in a pilot test.

**CMS should ensure that physician participants are able to send all record documentation to a reviewer before the reviewer makes a decision.** For example, documentation for a specific encounter may make a reference to documentation that appears in another place in the chart. The physician should be able to provide that documentation so the reviewer can make an informed final decision.

**ACP-ASIM also recommends that CMS reimburse pilot test participants for copying records.** Physicians deserve to be compensated as they would be responsible for obtaining and sending pertinent parts of the records, regardless if the record resides in the office, hospital, or other facility.
Immunity

CMS must offer reasonable assurances to physicians that they will not be penalized for participating in a pilot test. We recommend that CMS use the term “hold harmless” instead of “immunity” when discussing this issue. To strike a balance necessary to ensure adequate participation, CMS should:

- Blind the records it collects, as suggested by a Medicare carrier Medical Director at the CMS June 22, 2000 Town Hall meeting; and
- Limit audit liability to the specific claims included in pilot study.

CMS should assure that its carriers refrain from using sample claims in the pilot to initiate a broader review, except in the case of suspected fraud. By participating in a pilot, physicians will also be accepting self-imposed financial risk, even if they are held harmless. Physicians will subject themselves to an entirely new system—one in which they may undercode or be required to bill lower levels of service than under the current system—in the hopes that CMS can develop documentation guidelines that are fair to all parties. CMS must demonstrate a willingness to concede minor coding discrepancies (i.e. one level differences) while testing an entirely new documentation standard, and in some cases an entirely new method for selecting a level of service.

Medical Review

We are encouraged that Aspen Systems, the CMS contractor working on the documentation guidelines project, has asked medical organizations to provide feedback on the draft reviewer’s score sheet that it has developed from its review of the methods that are currently employed by carriers. CMS should make the score sheet available to the physician community after it is finalized and before it is implemented. Making the score sheet available to the public is consistent with CMS’s statement that program integrity means paying claims right. Access to the score sheet would enable physicians to accurately self-audit and prevent them from being surprised by carrier audit findings.

CONTRACTOR OVERSIGHT ISSUES

Provider Education, Customer Service, Medical Review, and Contractor Performance Evaluations)

Customer Service

Physicians typically base their perception of the Medicare program solely on the quality of interaction with their Medicare carrier. To many, the carrier is Medicare. ACP–ASIM is concerned that CMS has not done enough to monitor and improve physician-carrier relations. CMS should make addressing physician distrust of carriers—and therefore distrust of the
Medicare program—a top priority. Allaying physician concerns regarding carrier performance and intent will allow physicians to further focus on caring for their patients.

Program Integrity Customer Service Contract

ACP–ASIM is pleased that CMS plans to assess physician satisfaction with program integrity customer service. We are encouraged that CMS plans to conduct a survey to assess and improve the way it interacts with physicians to: develop local medical review policies, conduct medical review of claims, process enrollment applications, and respond to fraud complaints. **We recommend that CMS consult medical specialty societies to develop an action plan after analyzing the program integrity customer service survey responses.**

Billing and Coding Assistance Customer Satisfaction

ACP–ASIM believes that CMS must assess the quality of physician interaction with customer service personnel beyond program integrity. CMS must make an effort to understand physician perceptions and attitudes across the broad range of carrier interactions. **Specifically, the agency should survey physicians regarding their satisfaction with carrier personnel regarding billing, coding, and claim status inquiries.** Receiving feedback from physicians regarding the quality of carrier personnel in these areas should be assigned as high a priority as assessing the quality of program integrity interactions. **CMS should consult medical specialty societies to develop an action plan after analyzing the survey responses.** Our members cite failure to get a clear and/or consistent answer from carrier personnel as the most frustrating part of their interaction with the Medicare program. This discourages physicians from seeking answers from the entity that ultimately holds them accountable for their billing and coding decisions. The survey results would also help CMS identify deficiencies in its physician education processes.

Medical Review/Medicare Education and Regulatory Fairness Act of 2001

We commend CMS for implementing improvements to the Medicare medical review process through its corrective progressive action program. **However, we encourage the agency to make further reforms to enhance the fairness of the medical review process;** physicians must be considered innocent until the carrier demonstrates that the physician is at fault.

ACP–ASIM is a strong supporter for the Medicare Education and Regulatory Fairness Act (MERFA) of 2001. The provisions in the MERFA bill, which is gaining momentum in Congress, would address many physician concerns regarding medical review and improve the process by which CMS and its carriers educate physicians about Medicare rules and regulations. While we urge CMS to make the reforms contained in the bill, we continue to advocate for the enactment of MERFA.

Contractor Performance Evaluations

We believe it is important for carriers to be responsible for the service they provide to physicians. Assessing physician satisfaction with that service is an important first step to
assessing carrier performance. However, CMS needs to go further than surveys. Physicians must have real input into carrier performance.

**CMS should use a mechanism to collect and assess concerns about carrier actions so the agency is able to stay better informed regarding the performance of its carriers.** The GAO recently issued reports detailing CMS’s general lack of oversight of its Medicare carriers and other contractors. CMS cannot fully evaluate its carriers if it lacks a mechanism to collect documented inappropriate carrier actions. Also, the lack of such a mechanism unnecessarily antagonizes physicians by making it difficult for them to get relief for their valid concerns.

**CMS should establish a mechanism to assess valid regulatory hassles created by a specific policy or by carrier misinterpretation of CMS policy identified by state and/or national medical societies.** Carrier misinterpretation of national Medicare policy is problematic. There are numerous instances in which a carrier(s) implemented a policy that inappropriately denied or reduced payment for services that were billed correctly. Carriers are unlikely to recognize that their interpretation of a national policy is incorrect, leaving physicians no outlet to address their concerns. It is extremely difficult for physicians to get beyond the initial decision-making person or entity, even if the initial decision is incorrect.

Physicians need a mechanism to address valid concerns. It is imperative that CMS establish a process that taps into physician experience with carriers to monitor carrier performance. The process is also necessary so that physicians believe that Medicare is responsive to their legitimate concerns.

**A summary of our recommendations is included on the following page.**
ACP–ASIM Recommendation Summary

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Recommended Pilot Projects

Encounter Time

1. CMS should conduct a pilot test that allows physicians to select a level of E/M service based on encounter time with the patient with documentation of the E/M documentation “basics” as defined in the “general principles of medical record documentation” section of the guidelines.

2. CMS should update PPAC on the status of its comprehensive review of the encounter time contained in National Ambulatory Medicare Care Survey (NAMCS) data.

Outlier Approach

CMS should incorporate the CMA outlier approach into its pilot test(s).

Capturing Documentation Time Necessary to Adhere to Documentation Guidelines

All CMS-selected pilot tests should include a mechanism for assessing the amount of physician time and work involved in adhering to the documentation guidelines.

Proposed Pilot Study Specifications

- Length

CMS should allow nine months for pilot testing.

- Records Reviewed

1. CMS should ensure that physician participants are able to send all record documentation to a reviewer before the reviewer makes a decision.

2. CMS should reimburse pilot test participants for copying records.
Immunity

1. CMS should use the term “hold harmless” instead of “immunity.”

2. CMS should blind the records it collects, as suggested by a Medicare carrier Medical Director at the CMS June 22, 2000 Town Hall meeting.

3. CMS should limit audit liability to the specific claims included in pilot study.

4. CMS should assure that its carriers refrain from using sample claims in the pilot to initiate a broader review, except in the case of suspected fraud.

Medical Review

CMS should make the score sheet available to the physician community after it is finalized and before it is implemented.

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Program Integrity Customer Service Contract

CMS should consult medical specialty societies to develop an action plan after analyzing the program integrity customer service survey responses.

Billing and Coding Assistance Customer Satisfaction

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2. CMS should consult medical specialty societies to develop an action plan after analyzing the survey responses.

Medical Review/Medicare Education and Regulatory Fairness Act of 2001

CMS should make further reforms to enhance the fairness of the medical review process beyond the improvements made through its Progressive Corrective Action program.
Contractor Performance Evaluations

1. CMS should use a mechanism to collect and assess concerns about carrier actions so the agency is able to stay better informed regarding the performance of its carriers.

2. CMS should establish a mechanism to assess valid regulatory hassles created by a specific policy or by carrier misinterpretation of CMS policy identified by state and/or national medical societies.