Are the 1995 and 1997 Evaluation and Management Documentation Guidelines on Their Way Out?

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One of the more interesting aspects of the Centers for Medicare & Medicaid Services' (CMS) proposed Medicare Physician Fee Schedule rule for 2018 is a request for comments regarding the evaluation and management (E&M) documentation guidelines. According to the proposed rule, "Stakeholders have long maintained that both the 1995 and 1997 guidelines are administratively burdensome and outdated with respect to the practice of medicine, stating that they are too complex, ambiguous, and that they fail to distinguish meaningful differences among code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 In general, we agree that there may be unnecessary burden with these guidelines and that they are potentially outdated, and believe this is especially true for the requirements for the history and the physical exam."[1]

HISTORY OF THE EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES

Before we get too excited, let us look at the history of the E&M documentation guidelines, because this may hold a clue as to how CMS will approach revisions to these guidelines. It is worthwhile to note that CMS' previous attempts to revise the E&M documentation guidelines were met with a lack of consensus and support from stakeholders.[1] I hope that a good number of physicians, nonphysician practitioners, coders, and administrators commented on the proposed rule by the September 11, 2017, deadline, and that the specialty societies reached a consensus on this topic.

The 1995 E&M documentation guidelines came out in 1994. Because physicians felt that these guidelines favored internists and other primary care physicians, particularly in the exam component, the 1997 E&M documentation guidelines were developed. The 1997 guidelines contained certain specialty-specific physical examinations, and favored more subspecialists.[2] However, by 1998, specialty societies led by the American Medical Association (AMA) complained about having to "count bullets" in each of the 3 key components, including medical history, physical examination, and medical decision-making.[3]

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Physician specialty societies began to complain to Congress about the regulatory burden of the guidelines.[3]

In April 1998, at a national meeting in Chicago, IL, CMS (known at the time as the Health Care Financing Administration) suspended mandatory implementation of the 1997 guidelines.[4] That is why, today, payers can use the 1995 or 1997 guidelines, depending on which is most beneficial to the physician. In 1999, the AMA released new framework recommendations for E&M documentation guidelines, which were later dropped.[5] In June 2000, CMS revealed draft E&M documentation guidelines, which included clinical vignettes to help physicians decide the appropriate level of service to bill.[6] By December 2000, the AMA and other medical specialty societies began complaining about the way in which the clinical examples were being developed.[5]

In June 2001, approximately 40 physician organizations wrote to then CMS Administrator Thomas A. Scully requesting that CMS "take the next year to re-examine the imposition on physicians of burdensome evaluation and management (E&M) documentation guidelines, as well as its commitment to the development of 'clinical examples.'"[7]

"I am turning to the physician community to help design constructive solutions. After 6 years of confusion, I think it makes sense to try to step back and assess what we are trying to achieve," said Tommy G. Thompson, Secretary, US Department of Health & Human Services, in an announcement made in July 2001.[8]

Although some activity with the guidelines continued for almost another year, this initiative has been dormant until now, and physicians have suffered as a result of the delay.

UPDATING THE EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES

If the E&M documentation guidelines are to undergo meaningful changes, CMS and the physician community will need to work together and be ready to acknowledge that there probably is no perfect solution. A physician friend of mine used to tell me not to let perfect be the enemy of good—a lesson that surely applies here.

According to the proposed rule, in addressing the E&M documentation guidelines CMS stated that "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 [electronic health records] could improve documentation for patient care while also meeting requirements for billing and population health management."[1]

In addition, CMS asserted that they were seeking comments 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 visit levels....[and] whether clinicians and other stakeholders believe removing the documentation requirements for the history and physical exam would be a good approach."[1]

These are great starting points for an important and overdue discussion. I contend that physicians would embrace guidelines that place an emphasis on the complexity of medical decision-making over history and exam elements. To determine the level of decision-making needed for an encounter, the medical record would need to reflect the complexity—a problem list with a brief plan and no documented thought process would not represent this well.

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Initial resistance to having to document the physician's thought process will probably be offset by there no longer being a requirement for a specific number of systems in a review of systems, or organ systems and bullets that must be documented in the exam. If the main focus of documentation is to assess and plan for each problem evaluated during the encounter, the clinical documentation may be more intuitive for the physician and thus save time.

CONCLUSION

Pay attention to this proposal and participate in discussions that will follow. Get your physicians to understand that they have an opportunity to eliminate an administrative and outdated burden—but only if they opt not to sit on the sidelines or speak with disparate voices.

My comments on the proposed rule advocate leaving it up to the individual physician to determine how extensive the review of systems, past, family, and/or social history and physical exam should be, and that these elements should not be used for selecting the level of the visit. Instead, guidelines should use the descriptive elements of a good history of present illness, impression, and medical plan to drive code selection so that with good documentation, a patient with symptomatic lupus and fibromyalgia who is taking ≥2 drugs that can cause serious adverse effects is—with a good Subjective Objective Assessment and Plan note—a level 4 or 5 visit without extraneous information that has no clinical relevance.

How would you design a new E&M system? How would you get physicians to at least be reading from the same book, if not from the same chapter?

You can review the proposed rule at www.regulations.gov/document?D=CMS-2017-0092-0012. ■

REFERENCES

1. Centers for Medicare & Medicaid Services. Medicare program; revisions to payment policies under the physician fee schedule and other revisions to part B for CY 2018; Medicare shared savings program requirements; and Medicare diabetes prevention program. *Fed Regist.* 2017;82:33950-34203.
2. Centers for Medicare & Medicaid Services. 1997 documentation guidelines for evaluation and management services. www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/97Docguidelines.pdf. Accessed September 15, 2017.
3. Berenson RA, Basch P, Sussex A. Revisiting E&M visit guidelines--a missing piece of payment reform. *N Engl J Med.* 2011;364:1892-1895.
4. King SB III. President's page: evaluation and management documentation guidelines: proving accountability or just increasing hassle? *J Am Coll Cardiol.* 1999;33:895-896.
5. The American Academy of Orthopaedic Surgeons. HHS steps back from 3rd set of E&M guidelines. October 2001. www2.aaos.org/bulletin/oct01/fline1.htm. Accessed September 18, 2017.
6. Centers for Medicare & Medicaid Services. Draft evaluation & management documentation guidelines. June 2000. https://hscj.ufl.edu/college-of-medicine/compliance/documents/2000_e_m_guide.pdf. Accessed September 18, 2017.
7. American Academy of Dermatology Association; American Academy of Facial Plastic and Reconstructive Surgery; American Academy of Family Physicians; et al. Joint letter to Centers for Medicare and Medicaid Services administrator, Thomas Scully. June 29, 2001. www.acponline.org/acp_policy/letters/evaluation_management_documentation_guidelines_clinical_examples_2001.pdf. Accessed September 19, 2017.
8. O'Sullivan J. Medicare: payments to physicians. Updated March 3, 2003. https://burgess.house.gov/uploadedfiles/medicare%20-%20physician%20payments.pdf. Accessed September 19, 2017.