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E/M Documentation Guidelines
Comments Made for Consideration by CMS for the CY 2019 MPFS Proposed Rule
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Overview:

The 1997 E/M Documentation Guidelines (DGs) reflect how much of medicine was practiced and taught at the time they were created. The CPT codes and the DGs reflect the medical student history, exam, assessment and plan for the chief complaint that brings the patient to seek care. Many of the examples reflect a single disease or acute care focus. They also reflect the "more is better" era with positive weighting when ordering or reviewing more tests. The focus is diagnosis, not management. There is some recognition of chronic care management of the patient with multiple chronic conditions, but it stands out as a secondary focus. They pre-date the electronic record.

Medical practice has changed dramatically over the last 20 years. For geriatricians and other primary care physicians, the focus is now on management of chronic diseases and keeping patients out of the hospitals, emergency department and nursing homes using team-based care and education for self-management. Additionally, value-based care and population management of multiple chronic conditions using information systems that allow registries and performance measurement is the goal and is in wide practice in geriatric primary care.

The DGs are based upon the CPT structure and guidelines seeking to further define terms and standards in a quantitative manner for heuristic and audit purposes rather than measurement in patient quality of life or management purposes. It is unlikely that either CPT or the DGs will be modified, if modest CPT changes would result in requiring RUC review of E/M. Therefore, changes in guidelines is preferred as the first step necessary in changes to keep up with patient management changes.

The electronic record was designed around the DGs and not clinical care. Ironically, what began as program integrity has almost certainly resulted in an upward drift in coding, even beyond what would be legitimately expected by the improvements in care that the record allows. It has also resulted in copy/paste "note bloat" that buries meaningful information and hinders care and communication. Any DG system should not result in one specialty being favored over another for the same work.

Most clinicians use a relative sense of complexity. We have learned from the RUC process that clinicians do well within their field or patient population, but that cross specialty understanding or rank order is less precise. The average geriatric patient of the geriatrician usually has higher complexity than the "typical adult." The law of averages across the code range has diminished as physicians and NPPs limit their setting of practice and specialization has inexorably increased.

We will comment on the DGs, the problem with code levels in CPT as defined by the DGs, relationship codes (MACRA) and specialty codes (CPT).

DGs 1997 (Chapters and page numbers, as necessary, are provided)

I, II: Introduction and Principles: These are fundamentally sound, but the DGs do not adhere to them when used literally as is the case by most compliance officers and auditors.

III: Documentation: The first section notes that the DGs are for the typical adult patient and variation is appropriate in other cases. However, clarity as to acceptable variation is not detailed and thus by omission is effectively invalidated (p.4).

A. History: The PFSH and ROS are illustrative of rules that are unnecessary. For example, if the PFSH is unchanged it must be explicitly so noted. The details on acceptable documentation only leads to implausible or unnecessary systems review in many notes primary care clinicians review from other providers (p.6,8). The centerpiece is the "chief complaint" and the problem that leads to the visit. Most care is for ongoing chronic disease management for multiple problems. The follow-up is scheduled (p.6). Certain interval services require no such documentation (Hospital Inpatient and Nursing Facility), because it is acknowledged that if no change has occurred, no documentation should be expected (p.11), even though the interval between two office visits may be much shorter than the interval between two NF visits. In geriatrics, family history is irrelevant, whereas ADL/IADL and social supports is.

   We recommend that no documentation of PFSH or ROS be required to support the choice of a service level. Relevant items will be incorporated into the histories of present illnesses, though may be recorded in a ROS field for expediency. We recommend that only pertinent interval history items are used to support the choice of a service level.

B. Exam: The single specialty exams provide no parity across the specialties except to allow a "comprehensive" exam for all disciplines regardless of the actual time and work of the exam. A comprehensive skin exam is a fast and simple service that many generalists do as part of other services. It is the case that for different specialties that weight of history compared to exam is real. In geriatrics complex care often only requires a very limited exam, whereas in most of dermatology the history exists as much to have a courtesy verbal interchange with the patient and to gauge the concerns of the patient.

   We recommend that any weighting of examinations be equitable in terms of work across specialties. We recommend that exam be limited to the minimum clinically necessary areas, which in some cases may only include general observation and vital signs.

C. Medical Decision Making: Diagnosis and Management Options focuses on diagnosis. In most care, the focus is on ongoing management. Advising against diagnostic testing that may not change management or even cause harm is a major activity and can be stressful, when it does not comport to patient/family expectations after years of excessive testing and media reports (p 49). Data is all about the number of tests reviewed, when information about patient values, understanding of prognosis and active life expectancy may be more meaningful (p 50). Is such information history alone? The risk table generally is about action, i.e. has a volume orientation. However, it is commendable as the place where CMS articulates managing multiple conditions (p 52). Most geriatrics professionals would be reluctant to code the vast majority of their services as high complexity, even if they are. A single condition that is progressive (e.g. dementia) qualifies. De-escalation of treatment seems oriented to the ICU/hospital clinician, but could be more broadly interpreted. Nonetheless even if the "risk" is high, there is a requirement for two of three of the sub-

elements to meet the level. Greater emphasis is warranted for the interaction of function and disease and the care support needs of the patient. Medication management (and just getting an accurate list of medications) should be recognized. A major challenge in patient care results from arranging care plans around resources and patient caregiver health literacy.

We recommend a greater emphasis on multiple condition chronic care management and advising against procedures, building upon the work of the Table of Risk. We recommend that the number of medications, functional incapacity, social supports, social determinants of health, and health literacy be included as significant elements in determining the level of medical decision making.

D. Counseling and Coordination of Care (and Time-Based Coding): Much of care in geriatrics is counseling and care coordination, even during the face to face portions. Successful patient engagement and health outcomes correlate with positive clinician/patient relationship. Time with the patient promotes a positive relationship. A major incentive should not be to reduce time with the patients. At the end of the day, all professionals have a limited amount of time and widely disparate IWPUT devalues many specialties.

CMS should consider time as a factor in code level selection even when counseling and coordination of care do not dominate the service.

Code Level Compression and Patient Relationships

We believe evolving code reporting patterns suggest that the electronic record correlation with DGs has resulted in 99214 becoming the predominant service. Medically unjustified requirements of the DGs, particularly over history and exam, create a barrier between 99214 and 99215. Today, pre-visit planning, documentation time, quality measurement and patient portals represent significant time and resources for primary care E/M and most likely many others who manage patients on a continuous basis. Many patients are not 99213 based upon the MDM DG guidance, but few are 99215 based upon history and exam rules. 99214 has a wide range of patient types and much of the differentiation has been lost. If it is the case that all services by so many providers are correctly at this level due to changing practice, this could be more acceptable, but this is very questionable because the electronic health record makes it difficult to know what was really done at any specific visit. Additionally, the pre- and post- visit services of a specific level E/M vary significantly based upon patient relationship. The broad, continuous relationship is most time consuming. Specialty specific codes and relationship specific codes may be warranted. At least the DGs should better reflect these relationship variables.

We ask CMS to solicit comments regarding the use of patient relationship modifiers to establish new codes for services that do not easily fit within the E/M framework; that CMS solicit comment on (1) revising the DGs to take into account patient relationships and (2) on using the patient relationship codes in payment policy (e.g., making a higher payment when one physician has a broad continuous relationship with a patient who has multiple chronic conditions).

Specialty Specific or Service Specific E/M codes

AGS believes that 99483, Assessment and Care Planning for Patients with Cognitive Impairment is a good example of a code that was created because of the mismatch with the service and E/M. It is guideline-based and has very carefully defined required elements. It was accepted by the CPT Editorial Panel and recognized by CMS. There are other services that have elements that are not addressed in

E/M or the DGs. CPT declined to accept a Comprehensive Geriatric Assessment code in 2003 opining that E/M and other codes (e.g. physical therapy assessment) could be used to report the service. The evolution of the Panel and CMS over the last 15 years is significant. However, there does remain a general reluctance to have E/M to be used in a less than very broad method. It would be helpful if CMS provided concepts for comment and for the CPT Panel to consider regarding criteria that may warrant new specialty specific codes that define a distinct service with required elements so that E/M DGs don't apply at all. CMS has a history of creating useful guidelines such as those used in defining an eligible telemedicine service. See also comments above regarding relationships based coding.

We recommend that CMS state in the proposed rule that it will solicit recommendations for services that are not well defined by current E/M codes and that can be defined by requiring specific elements like the Assessment and Care Planning for Patients with Cognitive Impairment. Further, CMS should state that it will establish a process for soliciting proposals for such codes and publish them for comment in the proposed rule each year.

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Thank you again for this opportunity to submit feedback on behalf of the American Geriatrics Society. Should you have any questions, please feel free to contact me.

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