



E/M Services: Documentation Guidelines and Burden Reduction Listening Session

Moderated by: Leah Nguyen
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Operator: At this time, I would like to welcome everyone to today's Medicare Learning Network® Event. All lines will remain in a listen-only mode until the feedback session.

This call is being recorded and transcribed. If anyone has any objections, you may disconnect. I will now turn the call over to Leah Nguyen. Thank you. You may begin.

Announcements & Introduction

Leah Nguyen: I am Leah Nguyen from the Provider Communications Group here at CMS, and I am your moderator today. I'd like to welcome you to this Medicare Learning Network Listening Session on Evaluation and Management, or E&M, Services Documentation Guidelines and Burden Reduction.

CMS seeks comments from physicians and nonphysician practitioners on potential updates to the E&M guidelines to reduce burden and get better-aligned coding and documentation with the current practice of medicine. This listening session follows calendar year 2018 Medicare Physician Fee Schedule rulemaking and is part of an ongoing effort to seek input from stakeholders on these topics.

Before we get started, you received a link to the presentation in your confirmation email. The presentation is available at the following URL: go.cms.gov/npc. Again, that URL is go.cms.gov/npc.

At this time, I would like to turn the call over to Marge Watchorn, Deputy Director of the Division of Practitioner Services.

Presentation

Marge Watchorn: Thank you, Leah. And thank you to all of our participants for joining the listening session today. My name is Marge Watchorn, and I'm with the Hospital and Ambulatory Policy Group at CMS. I want to note that Ann Marshall was our intended presenter today, but she had a conflict. So, I will be taking her place.

I want to begin on slide 3 and just review for everybody the agenda for our call today. First, I'll be providing some background. Next, Leah will be providing information on some of the logistics. And then, we're going to have a structured audience response to questions in six areas regarding E&M.

The first set of questions will be broadly on ways to reduce burden associated with the documentation of patient E&M visits. The next set of questions will be a way for us to seek input from you all on approaches that other payers take to both the payment and the documentation regarding E&M visits. Next, we're going to get some information from you all on the role of each currently required item in the E&M visits, specifically the history, physical exam, and medical decisionmaking. Next, we would address documentation through changes to the underlying E&M code set itself. Next, we'll get information on duplicative data entry regarding visits that's in the medical record. And then, finally, we'll explore information about changes to the E&M visits that are specialty specific.



Background

So on slide 4, some background for you all. Billing practitioners, as I'm sure most of you are aware, must maintain information in the medical record which documents that they have reported the appropriate level of the E&M visit codes. Currently, the Centers for Medicare & Medicaid Services, as well as the American Medical Association, both maintain E&M documentation guidelines that specify the kind of information that distinguishes among the different levels for coding as well as payment. The agency has repeatedly heard over the years from stakeholders that these documentation guidelines are potentially outdated and that they need to be revised.

So in last year's Medicare Physician Fee Schedule proposed rule, the calendar year 2018 rule, we sought comments from stakeholders on specific changes that we should undertake in order to update those guidelines, specifically to reduce the burden associated with those guidelines and ways that we could better align E&M coding and documentation with the current practice of medicine. We received a variety of opinions in those comments. We summarized the comments broadly in the 2018 Physician Fee Schedule final rule. And the comments suggested that we provide additional avenues for collaboration with stakeholders prior to implementing any changes.

So really, this call today is part of our response to those comments. Today what we want to do is seek additional input from stakeholders as we continue to consider the issues for future rulemaking. And we're especially today seeking input from individual practicing physicians and nonphysician practitioners who bill E&M visits today.

And I'll turn it back over to Leah.

Logistics

Leah Nguyen: Thank you, Marge. Slide 5 outlines the logistics for this listening session. CMS is seeking input on six questions about E&M services. There'll be an opportunity to get into the queue for each question, so please limit your input to the topic that we announce. You will have a maximum of 3 minutes to provide your input. When your line is open, please provide your name, the practice/facility or professional association with which you are affiliated and its location, and your specialty or title/role. As a reminder, this event is being recorded and transcribed.

Question 1: Ways to Reduce Burden Associated with Documentation of Patient E&M Visits

We will now hear your feedback on Question 1 from slide 6. How can CMS reduce burden associated with documentation of patient E&M visits for billing?

All right, Dorothy, we are ready for our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset to assure clarity. Once your line is open, state your name, organization, location, and specialty or role. Please note your line will remain



open during the time you are providing your feedback, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the roster.

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Your first comment comes from the line of Margaret Reina.

Margaret Reina: Yes, my name is Margaret Reina, and I'm with Tulane University Medical Group in New Orleans. I'm the compliance officer. And particularly to me that the overall repetitive documentation of information that's already in the EMR, such as the elements of history, is truly duplicative. The physician on an established patient may only need an interval history, which may give very few "points," quote/unquote, to drive the level of service but not be medically necessary to be more extensive because there's so much else to refer to in the chart. And the level of the exam should be driven by the medical necessity of the encounter based on the physician's determination, his specialty or her specialty, their expertise, and on standards of medical care.

And so, repeating certain elements of exam, again, that may be available in the medical record from a previous visit may not change that frequently, you know, isn't necessarily helpful for patient care and it actually dilutes the provider's time with the patient. So, the predetermination that we see in certain elements to support the level of service, particularly in history and exam, that are used in the both the '95 and '97 guidelines really creates an unnecessary burden. Thank you.

Leah Nguyen: Thank you.


Operator: Your next comment comes from the line of David Glasser.

Dr. David Glasser: Yes, hi. This is David Glasser. I am the Federal secretary for the American Academy of Ophthalmology, and I'm in practice at the Wilmer Eye Institute in Baltimore. So five brief comments on reducing burden.

Reduce the number of levels from five to either three or four. Consider combining level 4 and level 5 codes. Number 2, base the levels primarily on medical decisionmaking and physical exam and de-emphasize history, but don't eliminate it. Number 3, simplify the medical decisionmaking tables. And I have some more details when we get to question 3 on that one. Number 4, simplify counting items for history in light of the EHR copy-forward capability and the large amount of data that stays in the record for re-review on every visit. And, number 5, do not overemphasize time—intensity and complexity are important. They need to be acknowledged. Thank you.

Operator: Your next comment comes from the line of Paul Rudolf.

Paul Rudolf: Thank you. Paul Rudolf representing the American Geriatrics Society on this issue. So first I want to agree with the previous commenters. And specifically, there are certain things this – the current guidelines are really outdated. They're geared toward the practice of medicine in the 1980s, and that's changed dramatically. There are things like family history and review of systems, which are not done every time a



patient comes in. And I would agree that they can be – as long as they’re documented once, then they don’t need to be redocumented. And they especially should not be counted toward a higher level of service. And the guidelines need to be revised to include things that are actually done, important to do, that should count toward a higher level of service, like functional status, which in geriatrics is very, very important.

So, we think that CMS can literally delete a number of items that – from the guidelines that should not count toward a level of service. That doesn’t mean that they’re not going to be done, because doctors do take a family history and they do periodically do a review of systems. But they shouldn’t necessarily count to a higher level of service. We also agree that medical decisionmaking needs to be simplified. And later on, I want to talk about the difference between chronic and acute illnesses. Thank you.

Operator: Your next comment comes from the line of Megan Adamson.

Dr. Megan Adamson: Hi. Megan Adamson, family physician with American Academy of Family Physicians and I’m located in a little practice in Dartmouth–Hitchcock in New Hampshire. So I would highlight some comments that were mentioned also previously, again, that the guidelines are outdated and reflect a time prior to team-based care. And so, the guidelines really ought to recognize that some of this information is input by staff members or by the patients themselves, especially for family history, social history, some of that review of systems, and would consider the elimination of some of the history and exam components; however, prior to that, focusing on getting a set of medical decisionmaking guidelines on which to base the evaluation of codes.

Leah Nguyen: Thank you.


Operator: Your next comment comes from the line of James Jerzak.

Dr. James Jerzak: Hi. I’m Jim Jerzak, a family doctor here in Green Bay with Bellin Health. I’m the physician lead for team-based care at Bellin. So I’d like to echo a little bit what the previous caller had mentioned. We have – our team-based care model involves our up-trained staff, CMEs and LPNs in particular, helping us out with team documentation. There’s a lot of difficulty with some of the requirements about who can actually write the HPI.

We understand that scribing is allowed. But these staff members go into the room and set up the agenda with the patients, and they’re somewhat unclear about how much they can do. I think to clarify how much they can do in the HPI as they’re setting up the agenda. To clarify and to loosen some of the restrictions on the community-based care staff models that are doing this type of documentation would be helpful.

And as we’re spreading team-based care, we’re having a symposium on team-based care here in Green Bay in April, and systems from around the country are coming to this. And we found this to be a barrier to a lot of systems that are trying to implement team-based care, in particular team documentation. So, whatever CMS can do to clarify and to make the ability of our staff to really do this meaningful documentation work would really be appreciated and would help us a lot as team-based care spreads. Thank you.

Operator: Your next question comes from – I’m sorry – your next comment comes from the line of Keith Horvath.



Dr. Keith Horvath: Hi. This is Keith Horvath, cardiothoracic surgeon and representing the Association of American Medical Colleges. I would completely agree with all of the points that have been made by the previous commenters and particularly with the redundancy that's built in along the lines of family history, social history, and review of systems. There needs to be some of that in the documentation. But it can be very focused, and it's probably best according to specialty. And I'll turn it over to the next commenter.

Operator: Your next comment comes from the line of Robert Blasier.

Dr. Robert Blasier: I'm Robert Blasier. I'm a children's orthopaedic surgeon in Little Rock and a practicing physician not representing anyone. I didn't get in medical school because I was a good typist or a note taker. I think my strength is interacting with patients, analyzing exam findings and test results, making diagnoses, and administering treatment. I understand the need for maintaining notes and medical record which document the patient's circumstance and treatment though. But a family is (inaudible) considering a lot of time documenting information which is marginally useful at best, for instance, to take the time to document a full review of systems including the negatives, family and social history, which is only rarely pertinent.

I think that goes with chest-specific examination findings, most of which are negative, for the purpose of generating points to substantiate a moderate level of billing. It takes a lot of time to dictate or type these into the chart. And this time could be spent better interacting with the patient and figuring things out. I find myself reviewing submitted clinical notes of others and wading through page after page of documented checked-off stuff trying to find the one or two sentences which tell me what's going on.

In summary, I waste a lot of time gathering and entering patient data which really doesn't help in the diagnosis or treatment of the patient's condition. So in practice, we document a number of bullet points that substantiate a level of history, level of exam, and level of decisionmaking, but these rarely really help the patient. It seems useful to me to maintain a medical record which is not exhaustive with detail but concentrate on what's important like, for instance, the patient's complaint, relevant review of systems and history, medicines and comorbidities, relevant exam and test findings, diagnoses, confounding factors that obscure the diagnosis, and recommended treatment plans. All little minutiae which aren't relevant should be omitted from this important, brief, easy-to-read narrative and could be entered in – other minutiae could be entered by nonclinicians.

So how should the clinician be compensated for his efforts? Well, it shouldn't be based upon committed bullet points but by time and effort. This suggests to me that E&M billing should be based on time, intensity, and medical decisionmaking, not bullet points. So, it seems basing the level of E&M service and medical decisionmaking would like to reward the cognitive specialist who spends a great deal of time and effort figuring things out as well as the surgical specialist who must entertain and explain surgical options to the patient.

In summary, my plea is to get away from bullet points, streamline encounter notes that are easy to read, and increase the number of possible levels of service and base reward for service on the intensity and time of medical decisionmaking. Thank you.

Operator: Your next comment comes from the line of Rachel Barron.

Rachel Barron: Hi. This is Rachel Barron in Phoenix, Arizona. And my comment has to do with patients who are home limited. We have a mobile practice group. And when home-limited patients are seen by our practice



group and attested that their home-limited status has been met by the physicians, that ought to be enough. And yet, we're finding often that that's brought into question.

And without having a specific set of criteria that they can follow to determine home limited, it is based on the clinical judgment of the provider. And yet, that doesn't always play out when we're under review. So, I would like for CMS to take that into account and either come up with some definitive criteria or accept the attestations of the providers that are seeing the patients in their homes. Thank you.

Question 2: Other Payer Approaches to E&M Visit Payment and Documentation

Leah Nguyen: Thank you. We are going to move on to our next topic. We will now hear your feedback on question 2 from slide 7. What approaches to payment and documentation do others outside of Medicare, such as private insurers, use for E&M visits by level? How do you take into account issues like history, physical exam and body systems, medical decisionmaking, face-to-face clinical time, non-face-to-face care among other issues? As a reminder, each participant has a maximum of 3 minutes to provide their input.

All right, Dorothy, we are ready for our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Remember to pick up your handset to assure clarity. Once your line is open, state your name, organization, location, and specialty or role. Please note your line will remain open during the time you are providing your feedback, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the roster.


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Your first comment comes from the line of Jean Acevedo.

Jean Acevedo: Yes, thank you. So I'm neither a physician or a nonphysician practitioner, but I am a compliance and coding consultant who's had the pleasure of working with hundreds of physicians and reviewed thousands of charts in my professional career. So, one of the things that I would ask in this category question that CMS understand is that most of the commercial payers, HMOs, etc. follow the evaluation and management documentation guidelines that CMS has published.

However, even the different MACs across the country have varying requirements for those same E&M codes. For example, a detailed exam by Palmetto GBA is nothing more than at least two elements of at least two body areas or two organ systems. Novitas has a four-by-four system where the physician has to have documented at least four elements of four body areas or at least four elements of four organ systems, causing confusion. A physician could have practiced in one state and found him- or herself in another and, all of a sudden, they can't pass the same Medicare audit.

Similar to that is the MAC's interpretation of documenting the family history. One of the MACs—it might be Novitas—is very clear that you can say "family history, noncontributory," and they understand what that means



and they'll count it. Most of them, however, will say that “noncontributory” means to them the clinician did not ask the question. Consequently, it's not a history element that can count for the level of service. So, I would just make sure – wanted to make sure that CMS understood that you also have to kind of look within in your own contractors in addition to looking outside for the commercial payers. Thank you.

Operator: Your next comment comes from the line of Maryann Palmeter.

Maryann, your line is open.

Maryann Palmeter: Hi. My name is Maryann Palmeter. I am the Director of Physician Billing Compliance for the University of Florida Jacksonville Physicians in Jacksonville, Florida. I would like to echo Jean's comments as far as E&M guidelines by other payers. For the most part, they do follow CMS's and, in turn, the AMA's guidelines for E&M. The variants between carriers and their interpretations are somewhat perplexing. Sometimes, they are silent and don't give an opinion. First Co Service Option is an example where they do not further define different levels of exam under the '95 guidelines, whereas other MACs have done so. I think there're some other interpretations by carriers like what constitutes physician workup for medical decisionmaking and things like that.

I also think that when we're talking about some of the managed care contractors, I think they tend to be more receptive to patients that have problems, but, at the same time, we're trying to deal with prevention during the context of one particular encounter. So, there seems to be a bit of a disconnect between fee for service and quality and performance improvement. And those are the comments that I have. Thank you.

Operator: Your next comment comes from the line of Priscilla Frost.

Priscilla Frost: Yes. My name is Priscilla Frost. I'm the executive director for the Bossier Parish Medical Society as well as a coding compliance auditor for a health care system. One of the biggest issues we see is that we have so many different payers who have their own interpretation. And the problem is if you – it's hard to tell a doctor or a mid-level, “For this payer, you bill the '95 guidelines. For this one, you have to use the '97.” So there is such inconsistencies not only with the other payers but, again, like everyone has stated, within the Medicare system. So I appreciate all the feedback that we're hearing today.

Operator: Your next comment comes from the line of Christopher Schenk.

Christopher Schenk: Hi. This is Christopher Schenk. I am the physician billing compliance manager with Dignity Health in California, Arizona, and Nevada. And you know, I agree with pretty much everything everyone else has said in regards to this question. The one item, too, you know, there's a lot of gray areas within the E&M guidelines. And I know that there are some payers like UnitedHealthcare and Anthem Blue Cross that actually further define on how to correct the code in E&M for those gray areas.

One I think specifically is within the medical decisionmaking and that they make it a mandatory component within, you know, certain codes that require two of these three components to code an E&M service. So, I think CMS can probably, you know, provide further clarification on some of those gray areas that have occurred over the last 20 years these guidelines have been out. Thank you.



Operator: Your next comment comes from the line of Lynn Rapsilber.

Lynn Rapsilber: Hi. My name is Lynn Rapsilber. I'm a nurse practitioner, and an NP business consultant. I teach coding and documentation to my colleagues, physicians, nurse practitioners, and PA. A couple of comments: One is I always get audits from the private insurers about how I am coding too high compared to my peers. But they really don't give kind of a guideline as far as how that bears out and where things fall within that. So, I don't get constructive criticism back.

The other area: The practitioner—when I do a wellness visit, which most patients don't pay for that and then they have a sick component because they have this list of things to do and then you tell them you need to collect their copay, oftentimes there's frustration with the patient. And if there's a better way to marry preventative care and finding a problem, I think that would be helpful.

And lastly, I hear a lot from my colleagues who will document correctly using E&M but the private insurers are kicking back because of the ICD codes used. Thank you.

Operator: Your next comment comes from the line of David Kanter.


David Kanter: Thank you. This is David Kanter. I'm VP of medical coding for MEDNAX Services, which is a multispecialty national medical group. I'm also a member of the American Academy of Pediatrics Committee on Coding and Nomenclature. And my comment relates to the fact that CMS Medicare provides leadership in this area of documentation guidelines and, in general, we find that other payers will use those guidelines as a takeoff point.

So CMS and Medicare carry great responsibility in establishing guidelines that apply effectively to multiple types of specialties. That becomes very important in pediatric care, where we interface with Medicaid quite often. And Medicare guidelines – even though Medicare doesn't cover a lot of pediatric patients, they have great influence on how payers adjudicate claims from a pediatric perspective. So, we do encourage CMS to consider pediatric care in establishing their revisions and modification of guidelines.

Two areas, for example, that demonstrate difficulties with current guidelines in pediatric care is the importance of pediatric care in interrelating family and caretakers when a patient may not be present. And that's effective care for the patient even though the patient may not be present, for instance, in a time-based visit. Another example would be a neonatal infant care, where the current guidelines regarding history may not apply to a patient who's not developed a mature history with regard to review of systems, for example. And those are areas where the current documentation guidelines have not really accommodated pediatric care very well. So we appreciate the opportunity to work with CMS in developing guidelines that apply effectively to pediatric care. Thank you.

Operator: Your next comment comes from the line of Leonard Reeves.

Dr. Leonard Reeves: Good afternoon. I'm Dr. Leonard Reeves. I'm a family physician in Rome, Georgia. I'm also on the Board of Directors of the American Academy of Family Physicians, and I speak for them today. Just, first off, echoing what everyone else has said, I agree with everything that has been said to this point. I would also like to point to a letter that was sent to CMS from the AAFP which has called for the elimination of



codes 99211 through 99215, also 99201 to 99205 for primary care physicians and allowing all members of the team to enter information related to the patient's visit.

As we're talking about fee for service, but we're moving in toward quality measures, we also see that insurers are imposing different quality measures than CMS. And we respectfully ask that CMS core quality measures collaborative – that they should look at the core quality measures collaborative findings as you go forward to look at those quality measures.

Most family physicians have to submit claims to more than 10 payers. And if we could somehow adopt a single set of quality measures and E&M codes of requirements, then it would certainly make the lives of most family physicians much, much more tolerable. Thank you.

Leah Nguyen: Thank you.

Question 3: Role of Each Currently Required Item

We are going to move on to our next topic. We will now hear your feedback on question 3 from slide 8. How much of a role should the currently required items—history, physical exam, and medical decisionmaking—play in supporting an E&M visit level for payment? What are the types of changes you would like to see made to each of these pieces? For example, what might be ways to change how medical decisionmaking is defined? Should CMS remove its requirements for recording history and physical exam, or should these requirements be reduced? If reduced, how?

All right, Dorothy, we are ready for our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Once your line is open, state your name, organization, location, and specialty or role.


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Your first comment comes from the line of Keith Horvath.

Dr. Keith Horvath: Hi. This is Keith Horvath, Association of American Medical Colleges, cardiothoracic surgeon, Washington, D.C. I think that the key portion that needs to be focused on is the medical decisionmaking. And it should be moved from a check-the-box system to determining the level of service and be focused, again, more on that clinical decisionmaking, specifically factors such as changes, additions, or significant clinical updates to the existing record, so again, looking at things that have happened since the last visit or new information, nature and intensity and the acuity of the presenting problem, and the number of problems, key elements. Management of medications, including the review of medications and the comorbidities, should also be included. And these are all important for that medical decisionmaking as is a review of allergies but only if there's a change. Diagnosis and treatment options are probably more important in many ways than an overly detailed history and physical, as well as discussion of coordination with other providers and potential referrals.

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And if applicable, the patient's expressed wishes for care options should also be documented. But it doesn't necessarily have to be part of the guidelines but would be important as far as using the medical record to confirm the medical decisionmaking process in each case. Thank you.

Operator: Your next comment comes from the line of Priscilla Frost.

Priscilla Frost: Yes. My name is Priscilla Frost. I'm with Bossier Parish Medical Society in Bossier City, Louisiana. I just would like to say just everything he just stated is exactly the feelings of most of the physicians. And I don't think that they need to waste their time documenting stuff that's not necessary. And I agree with what he said about the medical decisionmaking. Thank you.

Operator: Your next comment comes from the line of Jim Blakeman.

James Blakeman: Hi. This is Jim Blakeman from Emergency Groups' Office in southern California. I've been involved with coding and documentation issues since 1979. I have followed the development of the existing documentation guidelines. I want to suggest that those guidelines placed a lot of value on the history and physical, more so than probably reasonable. We believe that this places an undue emphasis on amount of information and not the relative importance for the complexity of care delivered.


The history and exam room—important contributors to medical necessity, but they don't deliver equal value. So, we're recommending that the agency consider revising the three-component documentation system—history, exam, and MDM—and remove the first two in favor of a two-component system. Medical decisionmaking, we propose, would remain the same, and you'd introduce a new category: number and complexity of presenting problems. So presenting conditions documentation would be the constellation of presenting problems, the complaints, signs, and symptoms that relate to the complexity, and then, the number of and types of comorbidities and relevant medical history, as it's in the system review or the medical history.

This new component would be scoring presenting conditions that define the reason for the encounter. So the complexity of the encounter is often embedded in the nature of the presenting problem and can be then identified in the way the medical decisionmaking works out, the tests that are ordered, the differentials, and so forth. So, we recommend a simplification. MDM would remain the same, but a new scoring system that identified the complexity of the visit inherent in the nature of the presenting problem. Thank you.

Operator: Your next comment comes from the line of Tom Sugarman.

Dr. Thomas Sugarman: Hello. My name is Tom Sugarman. I'm an emergency physician from California. And a lot of what I was going to say echoes what Jim Blakeman just said. I think that, given that the EHR now exists and medicine has changed since the mid-1990s, CMS should focus much more on evaluating what's needed for particular patients. So trying to check off certain boxes for HPI, then for past medical history, then for family history, then for review of systems, then for physical exam doesn't make much sense.

And so, putting it into fewer categories with more options for how to meet those categories, for example, using history and physical and data as one category, so back on information that one is using when evaluating a patient makes more sense than trying to parse it into very small pieces because, in some cases, for a new patient that you've never seen before who's very ill, then the history may be the most important thing. For – in



another case, a patient who can't speak at all because they're not able to talk, the physical exam may be much more important. And trying to force you into being into both those boxes makes not very much sense.

In terms of medical decisionmaking, the medical decisionmaking should reference how much data and how much information but also how many different options and what the reasoning is for not acquiring certain data. There's now somewhat of a perverse incentive under the CMS guiding – guidelines that ordering more tests and more different things leads to increased medical decisionmaking when, oftentimes, it takes more effort and more intensity of service and more cognition and more risk to not order those tests. And then, there's not enough of a reflection of how much time is spent with the patients to discuss the various options and to share medical decisionmaking. So I think those would be the changes I would recommend. Thank you.

Operator: Your next comment comes from the line of Hamilton Lempert.

Dr. Hamilton Lempert: Hello. My name is Hamilton Lempert. I'm an emergency physician with TeamHealth in Tennessee. I'm the chief medical officer for coding policy. My comments – I would agree with all the comments that have been stated before. The history and physical needs to paint a picture that justifies the medical necessity and medical decisionmaking that was done. And having check boxes to identify those sometimes doesn't make sense in painting the picture of what's going on with the patient.

I'd also recommend updating the risk table, to expand it so that it discusses more of the problems that are encountered, specifically, since I'm an emergency physician, in the emergency department but elsewhere as well. I would also ask that the idea of comorbidities be entered into the medical decisionmaking. And with all of this, you need to make sure if you change the CMS guidelines that this is done in coordination with the CPT codes because many of the CPT codes require a history and physical at certain levels. And of those, if the history and physical are eliminated or you change terminology without coordinating with CPT, that will create a great deal of confusion about how to code different levels.

And I would also echo the previous comment that medical decisionmaking is more than just simply ordering tests, that sometimes it takes a great deal more medical decisionmaking not to order a test and somehow accounting for that particular thought process that goes on in order to give credit for medical decisionmaking. That's all I have. Thank you very much.

Operator: Your next comment comes from the line of Linda VanHorn.

Linda VanHorn: Hi. This is Linda VanHorn. I'm the President and CEO of iShare Medical. We are a governmental trust anchor and an accredited trust anchor for exchanging health information nationwide. And I would like to bring up the issue of interoperability because I think the world has changed. And one of the things that is changing, too, is being able to provide care coordination across organizational boundaries.

And getting data from other providers is very important in the medical decisionmaking. And so you may not be recording it in your history, but you're certainly getting it from others. So a recognition – I think what matters in level of an established patient is what has happened since the last time that we saw them. And that includes like a med rec and things like that and then overweighting medical decisionmaking. Thank you.

Operator: Your next comment comes from the line of David Glasser.

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Dr. David Glasser: Yes. Thank you. It's David Glasser. I'm a practicing ophthalmologist in Baltimore and speaking on behalf of the American Academy of Ophthalmology. So of the three components—history, physical exam, and medical decisionmaking—the academy believes that it would be possible to discount or simplify the history requirements, maybe make it just a present or absent. But to continue the physical exam elements is an important component. The most complex portion of determining the level is the medical decisionmaking and also the most important.

And if we're looking to simplify and reduce burden, we should think seriously about reducing medical decisionmaking at three levels rather than four. So, rather than expand it to more levels, reduce it to maybe low, moderate, and high. And the medical decisionmaking risk table can also be simplified by reducing the number of risk levels to three: low, moderate, and high.

And finally, in looking at the three components of medical decisionmaking, retain the emphasis on number of diagnoses or management options and on risk. But remove the amount and complexity of data to be reviewed for consideration. So, it should really only have two variables in that portion of the table. I think those changes would significantly simplify the decisionmaking surrounding what level of medical decisionmaking is appropriate. Thank you.

Operator: Your next comment comes from the line of Megan Adamson.

Dr. Megan Adamson: Hi. Megan Adamson, family physician in New Hampshire and speaking on behalf of the American Academy of Family Physicians. And so I would echo some of what has already been said. But certainly, the current guidelines are overly burdensome without offsetting benefit to clinical care.

So, I would focus on reducing the redundancies in documentation, particularly those things that are already noted in the EHR, and reducing the complexity of the guidelines and would favor reducing or eliminating the history and exam portion. But, in updating the medical decisionmaking, those guidelines would be very – need to be very clear before ultimately being implemented and would support that needing to be in conjunction with update to the CPT code. Thanks.

Leah Nguyen: Thank you.

Question 4: Addressing Documentation through Changes to the Underlying E&M Code Set Itself


We are going to move on to our next topic. We will now hear your feedback on question 4 from slide 9. What are suggestions for updating documentation rules by changing the underlying E&M code itself? For example, what might be ways to stratify visits or alternatives to the existing number and type of levels?

All right, Dorothy, we are ready for our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Once your line is open, state your name, organization, location, and specialty or role.

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Please hold while we compile the Q&A roster.

Your first comment comes from the line of Brad Miller.

Dr. Brad Miller: Hi. I'm Brad Miller, a pediatric endocrinologist from the University of Minnesota. And I wanted to talk in this area about the importance for pediatric-specific and subspecialty-specific medical decisionmaking for chronic diseases. I think David Kanter mentioned how important making sure that pediatrics are considered here. And when Doctor – sorry – Sugarman and Glasser were talking about reducing the level of complexity, I think that's really important that we include the chronic nature of illnesses and their potential risks as we're assessing things. So, I think reducing the number of codes is important to that. So thank you.

Operator: Your next comment comes from the line of Paul Rudolf.

Paul Rudolf: Thank you. So the American Geriatrics Society believes very strongly that medical decisionmaking's of paramount importance and that history and physical should be minimized as much as possible. But, with regard to both questions 3 and 4, there needs to be a way to emphasize the medical decisionmaking for patients with multiple chronic diseases.

And specifically with regard to question 4 about splitting things out, the EMR is very difficult to understand when you're doing an audit because it's so redundant. Every visit is nine pages, and it's all just copied and pasted from the previous visit. There needs to be a way to figure out what was done since the last visit and just what the new medical decisionmaking was.


And we – and because of the EMR, everybody now reaches a level 4 or 5 visit based on the documentation. And CMS needs to do something about that. The suggestion we have is CMS could consider stratifying 99214 into two sublevels based on number of illnesses considered, number of diseases and the complexity of decisionmaking because we think there are a lot of visits that are really 99213 that are now being billed as 91 – 99214.

One of the things CMS could do that we think is a – is an interesting possibility is combining the new patient relationship codes with the payment policy in E&M so that it treats physicians who do broad continuous care like primary care doctors and geriatricians differently in the E&M guidelines and in payment for 99214 from others because of the issue of multiple chronic illnesses.

I would caution CMS in two regards. I worked at CMS for 5 years. And we tried to reduce the number of level of E&M codes back in the year 1999 and 2000, and we failed miserably. No one could come to an agreement on changing the levels down to four or six. I think that's a very – be a very difficult endeavor.

The other thing is I would caution against too many changes in the definition of medical decisionmaking. Certainly, simple things can tend to decrease it. But CPT did a huge 2 ½ year project on trying to define medical decisionmaking, and every specialty society that was a party to the AMA and CPT process participated. And that effort also failed. The numbers in the counting of four chronic diseases plus two acute or three diseases and nine medicines and this and that—it became a horrendously difficult process.

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So, I would urge CMS to look back at its own history as to what we tried to do about 15 years ago and what CPT did recently as you move forward on the number of levels and on the amount of – and how to define medical decisionmaking because it's very specialty specific. I think you've already heard the differences between endocrinology, emergency medicine, ophthalmology. And it's going to be hard to find commonalities that don't make things worse. Thank you.

Operator: Your next comment comes from the line of Nina Regevik.

Nina Regevik: Yes, I would just like to extend that – the thought about getting compensated – having codes for family visits when the patient's not present to getting codes for time spent referring to other subspecialists. I have an intensive internal medicine practice; I work at Hackensack Meridian. And we have very complicated patients. And I spend a lot of time with subspecialty referrals and getting feedback from them with no compensation essentially. Thank you.

Operator: Your next comment comes from the line of David Glasser.

Dr. David Glasser: Yes. It's David Glasser representing the American Academy of Ophthalmology. You know, I was going to just say one thing, which is reduce the number of levels to three or four. But you know, I listened to Paul Rudolf's comments and take them very seriously given his past experience. And my feeling is that when you try to develop a system based on a huge committee, you're going to have a lot of complexity and a lot of difficulty. And if the goal really is to simplify coding and documentation, you really need to simplify, not increase complexity.

I was intrigued by the comment on maybe bringing patient relationship codes into this so that that could expand the way to look at this without actually increasing and still possibly decreasing the amount of complexity involved in determining MDM and levels. Thank you.

Operator: Your next comment comes from the line of Maryann Palmeter.

Maryann Palmeter: Hi.

Operator: Maryann, your line is open.

Maryann Palmeter: Hi. Everyone else has pretty much covered my thoughts. Thank you.

Operator: Your next comment comes from the line of Keith Horvath.

Dr. Keith Horvath: Hi. The only thing that I would add—and I agree with the previous comments—is that the entire shift is towards clinical decisionmaking. The codes, whatever coding system is used, should be focused on that, and it can easily be simplified. And since we're having this conversation because the old documentation guidelines have become anachronistic, I think it's important to look to the future.

And as CMS, and all payers for that matter, may go over to the value-based system, coding documentation is not the place to spend our time. It's on the outcomes and quality metrics. So, you could argue that having any

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kind of different levels of coding, really, moot. However, if that needs to remain in place, it needs to be simplified to one, two, or three levels rather than the number that are presently existing.

Operator: Your next comment comes from the line of Cindy Hughes.

Cindy Hughes: Hello. I just wanted to comment that the current documentation guidelines are just too overly complex. And using medical decisionmaking, even as of itself alone now, is too complex. Coders argue over what's a self-limited problem vs. not, what falls into what category of risk. And it could be simplified down to a table of three categories with patient presentation, what data was reviewed, and what risks the patients face given their prognosis. I think that starting with the old guidelines may be a mistake and it's time to look for something fresh and new.

Operator: Your next comment comes from the line of Kimberly Wise.

Kimberly Wise: Hi. My name is Kimberly Wise, and I am manager of revenue integrity for Wheeling Hospital, and I perform the compliance auditing and training for the physicians. I've seen a huge problem with the EHRs and then trying to audit to the E&M levels. There's a lot of misunderstanding because the documentation guidelines don't mirror a clinically appropriate note.

So I don't know, but the good option I see is they usually document in their good notes in a SOAP format with just, you know, the appropriate subjective information and objective information. And the medical decisionmaking should lead it. And that would keep all this check box of unnecessary information cluttering up the real detail of the encounter, which is what everybody needs for their care. Thank you.


Operator: Your next comment comes from the line of Nihit Gupta.

Nihit, your line is open.

Your next comment comes from the line of Sandy Dixon.

Sandy Dixon: Hi. I'm Sandy Dixon. I'm the coding and compliance officer, North Carolina Metrolina Nephrology Associates. And I've been – I first want to say I'm very excited about this effort. I think it's long overdue. And I do agree with most of the folks that have gone before me, I think especially the lady that just spoke just a minute or two ago about, you know, when I think about documentation, I think of SOAP note. Subjective, Objective, Assessment, and Plan obviously is still the format we probably need to use I think for medical decisionmaking.

I think, for people that truly understand and utilize the guidelines the way the medical decisionmaking is currently set up, I think it's effective. I think when you're – you know, I know from my (inaudible) who are treating extremely sick patients they review a ton of outside documentation. You know, prior to seeing their patients, they have a lot of discussions with outside specialists, the whole nine yards. When they document that properly, I think that drives our medical decisionmaking effectively. Our patients also have a lot of comorbid conditions that we do properly document and get credit for.



However, I think the assessment and – or, I’m sorry – the history and physical exam is overly burdensome. I think if Medicare was to still require them but, say, you know, a comprehensive exam is no longer eight organ systems but, you know, all physical exams would just require, say, two systems. Right? I mean, you still want to be able to show that you touched the patient and that you were actually in the room with the patient. I think certain exam elements do do that.

And then again, you know, to mirror some of the things that have been said earlier in the conversation, just the relevant physical exam requirements so that we don’t – or, I’m sorry – relevant history require – elements so that we don’t have, you know, 9, 10 pages of useless information for, say, a level 4 followup visit. And I think that’s it. So just, you know, scale back the history and exam requirements, and stay focused on medical decisionmaking. Thanks.

Operator: Your next comment comes from the line of Betsy Nicoletti.

Betsy Nicoletti: Hi. I’m Betsy Nicoletti. I’m a coding and compliance auditor. I often joke that what we really need is a 99214 and a half because 99214 can be used for that patient who has a cough and gets an antibiotic or a prescription cough syrup and, also, for that patient who has four, five, six, seven, eight chronic problems where it doesn’t meet the requirements for the 99215. And I see that in primary care particularly.

I want to talk for a minute about the point system developed by the Marshfield Clinic which are not in the original guidelines. And this, also, I think has some odd incentives. So a new problem, otitis media, is more serious and complex than a patient who has one stable problem, diabetes in good control. And that affects both primary care and specialists. So an HIV specialist who has a patient who’s HIV positive and is in good control, that comes to low-complexity medical decisionmaking, which doesn’t make any sense in terms of the care that that patient is receiving.

And as we think about medical decisionmaking, you know, we coders are always talking about medical necessity and the nature of the presenting problem. Comorbidities are important too. So if you have a patient who has a cough and is 18 years old, that’s one thing. But if you have a 60-year-old patient who’s got COPD or heart failure and has a cough, even if the outcome is the same on the table of risk, the comorbidities should be factored into the level of service. Thank you.


Leah Nguyen: Thank you.

Question 5: Duplicative Data Entry Regarding Visits in the Medical Record

We’re going to move on to our next topic. We will now hear your feedback on question 5 from slide 10. Some stakeholders have suggested that CMS should not require documentation if the information already exists in the patient’s medical record. Which of the three elements does this apply to most (i.e., which of the requirements involve duplicative reentry of data that is already in the record)? Do stakeholders think this is a useful approach? How much burden would it relieve?

All right, Dorothy, we are ready for our next caller.

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Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Once your line is open, state your name, organization, location, and specialty or role.

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Please hold while we compile the roster.

Your first comment comes from the line of Stephanie Stinchcomb.

Ms. Stinchcomb, your line is open.

Your first comment comes from the line of Jene Skelly.

Jene Skelly: Sorry about that. Thank you. This is Jene Skelly, Director of Compliance and Finance at Mayfield Clinic North Surgery practice in Cincinnati. As others have already voiced, I think history is one of the big components where, if it's in the chart, it should not have to be repeated in today's office note or particularly taking that into the hospital setting with the consulting physician in the hospital having a level of service on a complex consultation be limited down to a level 3 on a consult or, in your instance, not even being able to get initial hospital care, because you don't have a family history element in your history in your note, seems punitive and it really does not contribute to the quality of care or the quality of documentation for that particular encounter. So, I would say history in the hospital setting.


I would also agree with the previously voiced opinion that the history of present illness and allowing that in the office setting to be documented by an MA perhaps confirmed by the physician and supplemented by the physician. But, in terms of being efficient in the office and having thorough documentation, it would really be helpful for CMS to remove the requirement that HPI be documented by an MA. Thank you.

Operator: Your next comment comes from the line of Megan Adamson.

Dr. Megan Adamson: Hi. Megan Adamson, family physician in New Hampshire speaking on behalf of the American Academy of Family Physicians. And we agree with other stakeholders that there is redundancy in the medical record relation. There is the physician-patient relationship and reduces access to one of the most valuable resources in that relationship, which is time. And so because in order to count for the current guidelines, it has to be restated in that event, really this applies primarily to that history of present illness, review of systems, past family and social history.

And as was mentioned by the last caller, you know, we would recommend that also being reflected that it could be entered by other staff members or by the patients themselves who are preexisting in the record. And really these redundancies contribute little towards patient care and quality outcomes. So, new documentation guidelines should really be aligned with clinical expectations and outcomes. Thanks.

Operator: Your next comment comes from the line of Stephanie Stinchcomb.



Stephanie Stinchcomb: Yes, hello. This is Stephanie Stinchcomb with the American Neurological Association, director of reimbursement and regulation, and I'm also an outside auditor. Our doctors have expressed their concern about the information that is in the EHR and having to, you know, worry about cloning and things like that. And they do feel that EHRs do not align with the guidelines and that they really need to not have to worry about something that's already in the records and having it brought forward.

And I also wanted to agree with Kimberly Wise, earlier, about the problems with the EHRs and how they really don't mirror a good clinical note and that agree with medical decisionmaking. And also, I think the physical – or the history is one of the areas that you really shouldn't have to worry about reentering that data. Thank you.

Operator: Your next comment comes from the line of Luana Ciccarelli.

Luana Ciccarelli: Hi. This is Luana Ciccarelli, and I am staff at the American Academy of Neurology speaking on behalf of our members today. We would just like to echo the comments of the previous speakers that mentioned the duplication of work and gathering information already in the patient record or in the MR.

Specifically, history need not be repeated unless it needs to be corrected. This is especially true of past, family, and social history and the review of systems. You know, only changes in the exam or new test results should be included. The documentation elements needed for billing, this should be collected automatically by the EHR or, you know, potentially an option by support staff as much as possible. There's not necessarily a need to repeat something that's already in the chart.

Another suggestion could be to allow noncritical information to be gathered and documented by other nonphysician staff or allowing the use of medical student documentation, like a tap into a resource that would alleviate some of the administrative burden on the providing physician. Thank you.

Operator: Your next comment comes from the line of Maryann Palmeter.


Maryann, your line is open.

Your next comment comes from the line of Hamilton Lempert.

Dr. Hamilton Lempert: Hello. This is Hamilton Lempert. I'm an emergency physician with TeamHealth in Tennessee. I'm the chief medical officer of coding policy. In the interest of time, I won't repeat similar comments that were made before. But I'd focus mine on the physical exam.

In the emergency department, the physical exam is performed in triage, and then by a nurse, and then by the physician. It is very common for the – it would be much better if the physician could focus their attention on examining the patient's complaints and just simply accepting the normal exam that has been performed by others as opposed to having to redocument their own personal exam and have to go through an entire exam.

I would also comment that the chief complaint should also be able to be documented by others. That is documented when a patient enters the emergency department and, again, needs to be redocumented by the physician. There is no reason to redocument this information a second time.



And I'll agree once again with the HPI and the past, family, and social history not being needed to be documented again by the physician if it's already been documented by somebody else. It would be good if we could align our documentation requirements to high-quality patient care and to patient flow in our current processes. That's all I have. Thank you very much.

Operator: Your next comment comes from the line of David Glasser.

Dr. David Glasser: Yes, it's David Glasser. I'm an ophthalmologist in Maryland and speaking for the American Academy of Ophthalmology. I think a common theme in the answer to this question and throughout the call has been the fact that it's not really necessary to keep redocumenting portions of the history that are already in the record. It takes time away from the patient encounter and really serves no purpose.

You know, one of the values of EHRs is ability to review and copy prior information without having to reenter it. Charting by exception is more efficient and, if done properly, highlights changes in the history and physical exam and really allows us to concentrate on what's important with the patient. And you know, we hear rumblings about cloning and how people just copy things without actually doing them. And I don't think that happens. I mean, I think you can make errors with an EHR and you can make errors with paper and pen.


But I think we really need to focus on charting by exception and not redocumenting things that are already in there. And then attempts to preclude copy forward is shortsighted and counterproductive and based on what I think an erroneous assumption that there's more harm done by copying (inaudible). The EHR already adds an immense burden to documentation of care and disallows one of the most important efficiencies it offers. It doesn't make sense. Thanks.

Operator: Your next comment comes from the line of Paul Rudolf.

Paul Rudolf: Thank you. So aside from echoing the previous comments, I think that CMS has an opportunity to do something really good and important because what's happened is, because of the guidelines, all the vendors that make – that sell EMRs are doing it in a way that maximize billing opportunities for doctors so they can document a level 5 visit every time a patient walks in the door. I think CMS needs to be very clear. I think it's supported by literally every caller that's called in, that the only things that should count are the history and physical that you have to do at that visit and the medical decisionmaking at that visit.

And CMS should be very clear that all these bullets and everything just don't count. You can't just paste everything into every note, that all that the auditors and anybody's going to consider is a little box that says "This is what I did at this visit and this is what has changed." And maybe you should even penalize people for placing everything in. I review a lot of medical records, and they are totally unreadable.

And right now, not only do we have a system that is supporting billing higher E&Ms than are deserved, they're also making patient care worse because everyone is wasting time wading through stuff that they shouldn't have to wade through. I would much rather see a handwritten note from a doctor in 1987, before the guidelines, that I could look at in 40 seconds and know what's going on with the patient than have to read through the EHRs today.



So, I think what AGS would encourage is something very simple, where it's very clear that only a certain number of things count at all and the rest is going to be completely disregarded, even something specific that, if it's in the note and it's – if we – send us two notes. And if anything in the note from April 1st is the same as the note from March 1st, it doesn't count because nothing's changed. And I really think that – and the EM – the vendor industry will then change all the EMRs to support that, and I think that the documentation and patient care will improve. Thank you.

Operator: Your next comment comes from the line of Lynn Rapsilber.

Lynn Rapsilber: Hi. I agree with all the comments that have been made previous. I think this has been a great discussion of some of the frustrations that we all have as providers. I do agree that the medical decisionmaking is what really makes that patient visit unique, what we're going to do for that patient. And I agree spending more time on that would be helpful.

I also like the comment that somebody had made about maybe kind of rolling these up and relooking. And it might be good to get a think tank of providers together of which the nurse practitioners would like to be part of that to have that discussion.

My only caution with documentation right now is we're concerned about rendering providers and billing providers when it comes to the quality payment model and getting credit for the quality work that the providers are providing. One of the things that I hear comments on is about incident 2. We're not getting – the nurse practitioners and PAs are not getting credit for the quality markers. So, I would hope that there would be some way to make sure that the rendering provider and the billing provider, that that connection's there for the QPP in the future. Thank you.

Leah Nguyen: Thank you.

Question 6: Specialty-Specific Changes

We are going to move on to our next topic. We will now hear your feedback on question 6 from slide 11. Should there be any specialty-specific changes to the documentation guidelines? And if so, what?


All right, Dorothy, we are ready for our first caller.

Operator: To provide your feedback, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, press the pound key. Once your line is open, state your name, organization, location, and specialty or role.

Please hold while we compile the roster.

Please hold while we compile the roster.

Your first comment comes from the line of Maureen Corcoran.



Maureen Corcoran: Hi. This is Maureen Corcoran. I'm the lead coder from SUNY Upstate in Syracuse, New York, in emergency medicine. One of the things that I want to present is teaching-physician guidelines. I don't see the purpose of having them sign off on the chart and then having to also do a resident attest for the resident's note and a procedure tie-in for the procedure note too. And also, consults vs. new patients—we have many insurances that will not accept consult codes and we have to code in new patients, and it's not an easy crossover, because there's different documentation guidelines. So I think they should be consistent across the board. Thank you.

Operator: Your next comment comes from the line of Catherine Hill.

Catherine Hill: Hi. This is Cathy Hill with the American Association of Neurological Surgeons and Congress of Neurological Surgeons. And I just wanted to follow up on the consultation code issue. And I – sorry I didn't mention it when we were talking about private payers. But AANS and CNS support the reinstatement of the consultation codes for some of the reasons that a few people have mentioned and that we wanted to make that clear and ask CMS to look to the CPT consultation codes and to reinstate them. Thank you very much.

Operator: Your next comment comes from the line of Lindsay Botsford.

Dr. Lindsay Botsford: Good afternoon. I'm Lindsay Botsford, and I'm a family physician in Houston, Texas, speaking on behalf of myself and also work for a hospital system and large residency-based clinic. I think, specific to the question, especially specific changes in primary care, there's a significant gap that exists between a 99214 and a 99215. Now, some of that could be alleviated by the comments from earlier commenters with simplifying medical decisionmaking overall.

But, for the management of chronic conditions in primary care, it's very easy to get to a level 4 if you know how to code correctly. But, unless you have that much more complex case, very hard to get to a five, which disincentivizes addressing multiple chronic conditions in one visit, which is really what we'd like to be doing. So, I think that is somewhat unique to primary care, although certainly could evolve in some – to some of the other cognitive specialties where you're managing complex interactions that just don't seem to be captured in the current documentation guidelines.


Operator: Your next comment comes from the line of Jan Blanchard.

Jan Blanchard: Hello. I'm Jan Blanchard. I'm a pediatric E&M audit specialist in – near Burlington, Vermont. I just wanted to reiterate the importance of the link between Medicare in these instances and to support the idea that was brought forth earlier to add assistance to the risk table and all of the medical decisionmaking tools in general to apply these concepts and requirements to pediatric cases. Thank you.

Operator: Your next comment comes from the line of Lena Truncale.

Lena Truncale: Hello. My name's Lena Truncale. I am a senior coding and revenue cycle educator of NorthShore University HealthSystem Medical Group. One of the things that we frequently – in doing education with our providers from different specialties and, in particular, otolaryngology, regarding the physical exam, it's just – if there's revamp that's going to be done for the physical exam, considerations for the different specialties should be included.

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For example, for '97 utilization order, assessment of hearing with a tuning fork, a tuning fork is just not used as frequently, if any, during those examinations. Also, psychiatry with a psychologist. The constitutional aspects of the exam, most psychiatrists do not use vitals that poses as a finding. It's currently with documentation concerns. Also, with musculoskeletal exam and the different orthopaedic specialists. If their focus is primarily the hand, it's very hard for them to obtain those higher levels in the exam aspects that's required currently.

So, in looking at the specialty specific for different specialists, we ask that CMS also consider that and look – and work with the different specialty associations, which has already emulated on some of those things already with other specialties to look at the aspects of the physical exam in regard to documentation guidelines. Thank you.

Operator: Your next comment comes from the line of Dena McDonough.

Dena McDonough: Hi. This is Dena McDonough. I work with the American Academy of Orthopaedic Surgeons, and I'm also an orthopaedic physician assistant. I'm echoing what others have mentioned regarding the extensive H&P that's not always pertinent to the reason for the visit and specifically for orthopaedics. When we're dealing with someone who has an acute injury, getting an extensive family history or a very detailed history is just not necessary to treating that problem. Thank you.


Operator: Your next comment comes from the line of David Kanter.

David Kanter: Hi. Thank you. Dave Kanter with American Academy of Pediatrics and MEDNAX Services. And I wanted to thank CMS again for recognizing all the specialties and the importance of documentation guidelines as it applies to multiple specialties, including pediatric care, which obviously is not a Medicare-dominant specialty but still relies on Medicare guidance such as documentation guidelines. I wanted to thank Betsy Nicoletti for bringing up the issue of multiple chronic conditions that might be stable or changing as expected and, therefore, it may not necessarily elevate the conventional approach to medical decisionmaking and the need to recognize that concept. That does apply to children with special health care needs.

Another important concept regarding children with special health care needs is the fact that their development is evolutionary changing with each visit. And although we do agree that medical decisionmaking plays a dominant role in terms of evaluating new guidelines, there are situations where history becomes a dominant work requirement to the physician. And that may apply to a child with special health care needs who needs to be assessed developmentally from a history standpoint, where conventional medical decisionmaking may not necessarily apply but an extensive history is required in order to fully assess that patient in terms of that evolutionary development.

There are ways to recognize that kind of work. So for instance, time could be one way to recognize that work as opposed to detailed history elements. But currently, time is somewhat restrictive with regard to counseling and coordination of care. So, that may be another area worth looking at in terms of expanding the role that time can play in terms of recognizing physician work during the visit. Thank you.

Operator: Your next comment comes from the line of John Bowman.



John Bowman: John Bowman, compliance officer for OrthoVirginia, a large 111 orthopaedic – the main orthopaedic group in Virginia. In my life as a board member at a hospital, we always emphasized the case mix index as a way for reimbursement. And I would think that with all the sharing that goes on between EMRs as interoperability increases, all of our charts will be – will really begin to reflect the severity of in – of illness at each particular patient we see. And at that point, I think we could reduce much of the burden of documentation by going to a system that rewarded us on time that was then factored in with the case mix index of the patient and severity of the illness of that patient. And that may be a better way to reimburse us. Thank you.

Operator: Your next comment comes from the line of Megan Adamson.

Dr. Megan Adamson: Hi. Megan Adamson, family physician in New Hampshire speaking on behalf of the American Academy of Family Physicians. And the AAFP had previously called for documentation guidelines to be eliminated for codes 99211 through 99215 and 99201 through 99205 for all primary care physicians in all three domains: history, physical exam, and medical decisionmaking. If CMS eliminates the occupation – documentation requirements for history and physical exam domains only, then it would be important for the guidelines to support medical decisionmaking driven E&M documentation. And it really should be in place prior to those changes happening. Thanks.

Operator: Your next comment comes from the line of Jean Acevedo.

Jean Acevedo: Hi. Thank you so very much. I was going to speak about time. And coincidentally, a couple of people have interjected time. This question leads me to want to discuss it relative to specialty-specific instances. We shouldn't lose track of the amount of time spent. Two examples.

Take a rheumatologist who's speaking with a young female, newly diagnosed lupus patient who wants to get pregnant. Neither the history nor the exam is anything that he or she is interested in today. But that is a complex situation, and we need to make sure that we can still allow physicians to bill based on time.


Same goes for a lot of hospice and palliative medicine physicians and nurse practitioners we work with who are dealing with the severity of very longstanding chronic illnesses that are maybe taking a downward trajectory and, again, where the history in that case is probably extremely important, physical exam is probably only being done because of what one participant called the need to feel like you have to touch the patient and the patient's feeling that need. Right? But, for certain circumstances – that results visit, that dramatic change in a downward fashion of the patient's disease process, etc. – at times should indeed continue to be an available component when appropriate.

And thank you, CMS, for opening up this call for all of us. I, too, went through the debacle at this time, or at least unsuccessful round of the 2000 guidelines. So, it's very nice to hear that everybody seems to be on at least one same page here, that we need to be looking at medical decisionmaking and not be worrying about who actually documented the history of present illness. So, my thanks to you, CMS.

Operator: Your next comment comes from the line of Edward Gaines.

Ed Gaines: Hi. This is Ed Gaines. I'm with Zotec Partners, Chief Compliance Officer, and too was around in '93-'94 when the Medicare documentation guidelines were promulgated and then in '97. So, I've been in this

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for a while. And I want to echo comments that Doctors Lempert and Sugarman made and also Mr. Blakeman. And I appreciate CMS's effort here to ask us for feedback and to listen to our thoughts about this. Many of us deal in these areas every day from an education quality compliance standpoint. So, these guidelines are critically important to us.

But I would be remiss if I did not ask that time not be considered an element for emergency medicine. It wasn't in the and isn't in the CPT structure of the Medicare documentation guidelines, outside of the critical care codes, of course. And I would say for the E&M levels that that concept be continued because I think it is – it served emergency patients and emergency physicians well that time was not a factor for those codes. Thank you very much.

Operator: Your next comment comes from the line of Brad Miller.

Dr. Brad Miller: I just wanted to echo the pediatric-specific issues of development and history that are relevant for a pediatric endocrinologist. Sorry. I'm a pediatric endocrinologist at the University of Minnesota. But I think that we have to look at the complexity of the patients that we're seeing, whether it's adrenal insufficiency or type 1 diabetes, and have chronic illnesses that could be high risk, especially in a teenager who's not taking their medications, and try to figure out how to capture that in the medical decisionmaking because I think, if we just base on medical decisionmaking, a lot of what a pediatrician and a subspecialist does gets undervalued. And so, I think that's an important thing.

Lastly, data documentation was – continuous glucose monitoring, etc. and all the data that we have on laboratory and imaging, although an ophthalmologist says decrease it, I think we have to consider that in the medical decisionmaking that we're doing. Thank you.

Leah Nguyen: Thank you. I'll now turn the call over to Marge for some closing remarks.

Additional Information

Marge Watchorn: Thank you, Leah. I want to reiterate what we said at the outset of the call. The feedback that you have provided for us today is extremely valuable. And thank you so much for everyone who took their time out to listen and, in particular, those, you know, who provided us the feedback today.

I also want to remind you that our conversation today in this session is really part of an ongoing effort on the part of CMS and that any changes that we would propose to either coding or documentation requirements would be addressed in the calendar year 2019 Physician Fee Schedule proposed rule, which is scheduled to be published generally on July 1st of this year. And the proposed rule, of course, will, as it always is, be open for public comment. So, we do hope that the folks who were on the line today will take a look at the proposed rule and provide your thoughtful comment for the agency's consideration in the final rule and going forward. And that's all I had. Thank you, Leah.

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Leah Nguyen: Thank you. Again, my name is Leah Nguyen. I would like to thank our presenter and also thank you for participating in today's Medicare Learning Network Listening Session on E&M Services. Have a great day, everyone.

Operator: Thank you for participating in today's event. You may now disconnect. Presenters, please hold.