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A MEDICARE LEARNING NETWORK® (MLN) EVENT

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

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Presenter:

Ann Marshall
Hospital & Ambulatory Policy Group

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES

Medicare Learning Network®

Acronyms in this Presentation

- CMS – Centers for Medicare & Medicaid Services
- E/M - Evaluation and Management

Agenda

- Background
- Logistics
- Structured audience response to questions in 6 areas
  1. Broadly, ways to reduce burden associated with documentation of patient E/M visits
  2. Other payer approaches to E/M visit payment and documentation
  3. Role of each currently required item (history, physical exam, and medical decision-making)
  4. Addressing documentation through changes to the underlying E/M code set itself
  5. Duplicative data entry regarding visits in the medical record
  6. Specialty-specific changes

Background

- Billing practitioners must maintain information in the medical record that documents that they have reported the appropriate level of Evaluation and Management (E/M) visit codes.
- The Centers for Medicare and Medicaid Services (CMS) and the American Medical Association maintain E/M documentation guidelines that specify the kind of information that distinguishes among levels for coding and payment.
- CMS has repeatedly heard from stakeholders that these guidelines are potentially outdated and need to be revised.
- In the Calendar Year 2018 Medicare Physician Fee Schedule proposed rule, CMS sought comment from stakeholders on specific changes CMS should undertake to update the guidelines, reduce the associated burden, and better align E/M coding and documentation with the current practice of medicine.
- Commenters expressed varying opinions (summarized in the final rule) and suggested that we provide additional avenues for collaboration with stakeholders prior to implementing any changes. Today CMS is seeking additional input from stakeholders as we continue to consider the issues for future rulemaking. We are especially seeking input from individual practicing physicians and non-physician practitioners who bill E/M visits.

Logistics

- CMS will pose 6 questions.
- For each question, participants will be queued and have a maximum of 3 minutes each to provide input/opinion.
- When responding, please provide your name; the practice/facility or professional association with which you are affiliated and its location; and your specialty or title/role.
- Please note: The information CMS gleans from this listening session will be used to help develop policy proposals for upcoming notice and comment rulemaking. Listening sessions are simply one avenue that the agency is using to obtain feedback from practitioners and other interested stakeholders regarding E/M visits. There will be additional opportunities for input in the coming months.

Questions for Participants

1. How can CMS reduce burden associated with documentation of patient E/M visits for billing?

Questions for Participants

2. What approaches to payment and documentation do others outside of Medicare, such as private insurers, use for E/M visits by level? How do they take into account issues like history, physical exam and body systems, medical decision-making, face-to-face clinical time, non face-to-face care, among other issues?

Questions for Participants

3. How much of a role should the currently required items (history, physical exam, and medical decision-making) 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 decision-making is defined? Should CMS remove its requirements for recording history and physical exam, or should these requirements be reduced (if reduced, how)?

Questions for Participants

4. What are suggestions for updating documentation rules by changing the underlying E/M code set itself? For example, what might be ways to stratify visits or alternatives to the existing number and type of levels?

Questions for Participants

5. 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 re-entry of data that is already in the record)? Do stakeholders think this is a useful approach? How much burden would it relieve?

Questions for Participants

6. Should there be any specialty-specific changes to the documentation guidelines, and if so what?

Thank You

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