

Evaluation and Management Documentation Guidelines June 22, 2000

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HCFA Status Report on Revising the Documentation Guidelines for E/M Services

THE NEW DGs

To determine the level of service:

$$\left(\begin{array}{c} \text{Hand} \\ \text{99} \end{array} (\text{HPI} + \text{PFSH}) \rightarrow + e\tau\text{ROS} + \text{PE}^3 + \text{MDM} \odot r^2 \right) \div \# \text{ of MINUTES} = \text{LOS}$$

Overview

- Goals for Documentation Guidelines
- History of the Documentation Guidelines
- Concerns over previous guidelines
- Alternative Approaches
- Technical Assessments

Overview

- HCFA's Analysis of its technical assessments and the DGs
- HCFA's Planned Approach
- June 2000 DGs
- Proposed studies
- Process Issues

Goals for Documentation Guidelines for E/M Services

- Develop and Implement E/M DGs that are consistent with current standards for documentation
- Require what a practicing physician considers clinically appropriate

Goals

- Improve Consistency of Physician Coding
- Improve Reliability of Medical Review
- Facilitate accurate Payment
- Ensure Work Equivalency across specialties

Scope

- E/M services account for \$18 Billion/year
- E/M services represent 40% of spending for physician services
- HCFA is responsible for assuring proper payment

Current Structure

- Developed in 1992 simultaneously with the physician fee schedule
- **CPT Structure** - types and levels of service - describing Work - # of levels, types of patients
- **CPT Descriptors** - the “work” of an E/M service - Time? History? Physical Exam? Medical Decision-Making?
- **CPT Descriptors** - relative work - Amount of History? Physical Exam? Decision-Making?

History

- CPT definitions - Insufficient?
- Documentation Guidelines - to supplement and clarify the CPT definitions
- 1st set - 1995 DGs
- Problems with the 1995 DGs - Single System Exams
- 2nd set - 1997 DGs

More History

- Problems with the 1997 DGs:
 - single system exams, counting, bullets, shading, medical decision-making
 - burdensome, time consuming, too complicated, detracted from patient care
- Current status - Reviewers use 1995 and 1997 DGs whichever is better for the physician

Even More History

- HCFA commitment to look at alternatives, pilot test, educate
- 1998: The “New Framework” - a starting point?
- 1999: transmission of “proposed 1999” DGs

Proposed 1999 Dgs

- Based on “New Framework”
- Counting continues - simplified
- Impossible to “warrant” work equivalence for single system examinations
- Qualitative CPT definitions vs. Quantitative Counting - which is more important?
- Proposed 1999 DGs - never tested
- HCFA agreed to review them as part of larger effort

HCFA Review (1)

- Started in June 1999
- Shared concerns with practicing physicians about the 1997 DGs
- Concerned about incentives to perform unnecessary services or document irrelevant information to bill a higher level of service

HCFA Review (2)

What did it involve?

- Technical Assessments
- Assessed Several Proposals for DGs:
 - Proposed 1999 DGs
 - Peer Review of Outliers
 - Time
 - Fewer Levels of Service

HCFA Review (3)

- Specialty Specific DGs - e.g. pediatrics
- Modify 1995 DGs
- Vignettes
- Medical Decision-Making

HCFA Review (4)

- Technical Assessments:

I - Effect of the 1995, 1997, and proposed 1999 DGs on assigned level of service and variation in assigned level of service between reviewers

II - Review of Physician Outliers by 1995 and 1997 DGs

HCFA Review (5)

Effect of 1995, 1997, proposed 1999 DGs

Results:

- Non-physician reviewer assigned a lower level of service when using 1997 DGs
- Physician reviewer assigned a higher level of service when using the proposed 1999 DGs

HCFA Review (6)

- Physician Reviewer - increase in variation of the assigned level of service when using proposed 1999 DGs
- Assigned levels of service never more than one level different from billed level
- Variation between the two reviewers significantly greater when using the proposed 1999 DGs

HCFA Review (7)

- Much of variation was due to differences in evaluation of medical decision-making component

HCFA Review

Review of Physician Outliers

Results:

- 95% of claims denied or assigned a lower level of service no matter which DGs
- 40% denied; 57% assigned a lower level of service
- more claims assigned two levels of service lower with 1997 DGs

HCFA Analysis (1)

Technical Assessment:

- 1995 DGs result in more consistent, reliable medical review
- Due to variation in interpretation we need to carefully evaluate DGs for medical decision-making
- Suggests outliers will fail any set of reasonable guidelines

HCFA Analysis (1A)

- Medical Review needs to focus on outliers but DGs will play bigger role in assigning a level of service to claims from physicians with typical billing patterns
- DGs important for assuring proper payment

HCFA Analysis (2)

Analysis of the DGs:

- Lack of work equivalence across specialties with 1997 DGs and proposed 1999 DGs (requirements for examinations and decision-making not equivalent)

HCFA Analysis (2A)

- Deviation of 1997 and proposed 1999 DGs from the CPT definitions for examinations and medical decision making
 - Examination - Could satisfy numerical requirements but fail qualitative requirements of the definitions
 - Decision Making - factors rearranged and altered - assigned level based on a single factor

HCFA Analysis (3)

Other concerns:

- Unacceptable incentives with the 1997 and proposed 1999 DGs to perform unnecessary services
- Medical Decision-Making - table confusing, rigid, list of examples irrelevant to most E/M services or incorrect

HCFA Analysis (4A)

- Likely that any set of DGs with lots of counting and/or tables will create wrong incentives and deviate from CPT definitions
- Some of the problems attributed to the DGs are really attributable to the CPT definitions
 - e.g. much of the confusion and concern was due to discordance between the DGs and the CPT definitions

HCFA Analysis (4B)

- Need to find alternative to counting that will also track the CPT definitions - counting will only exacerbate current problems

HCFA Analysis (4)

Conclusions:

- No further study of the 1997 and proposed 1999 DGs
- No further study of outliers
- Minimize Counting
- Emphasize documentation of clinically relevant care; minimize use of rigid, potentially irrelevant tables

HCFA's Analysis (5)

Conclusions:

- Further study needed to validate the current CPT structure and descriptors for E/M services

HCFA's Planned Approach

- (1) Develop draft DGs
- (2) Study draft DGs
- (3) Modify draft DGs if appropriate
- (4) Finalize new DGs
- (5) Educate physicians and reviewers on new DGs
- (6) Implement new DGs

HCFA's Planned Approach

- (7) Work with the AMA CPT Editorial Panel to develop and implement, as appropriate, new descriptors and/or a new structure for reporting E/M services

The June 2000 Draft DGs

Draft DGs

- Title: June 2000 DGs
- Basis: commitment to continued use of the current CPT structure and definitions - draft DGs should track the CPT definitions
- Similar to 1995 DGs - same key components

BUT

The June 2000 Draft DGs

- Simpler, Clearer
- Supplement draft DGs with specialty specific vignettes for physical examinations and medical decision-making
- Vignettes crucial for accurate assignment of level of service and distinguishing between levels of service

The June 2000 Draft DGs

History:

- Similar to 1995 DGs
- HPI: Brief (1-3 elements), Extended (4+ elements)
- HPI: Emphasis on follow up visits, patients on multiple medications, and patients requiring medication management

The June 2000 Draft DGs

History:

- ROS: Brief (1-2), Extended (3-8), Complete (9+) - documentation standards more clinically relevant, e. g. notation that a system was negative is sufficient (ROS: Cardiac, Pulmonary, GI, GU - all negative)
- PFSH: Pertinent/Complete - Similar to 1995 DGs

The June 2000 Draft DGs

Physical Exam:

- No bullets
- No shading
- No required elements
- Minimal Counting
- Multi-system and Single System Exams

The June 2000 Draft DGs

Physical Exam:

- Three Levels
- Multi-System Exam:
 - Brief (1-2 organ systems or body areas)
 - Detailed (3-8 organ systems or body areas)
 - Comprehensive (9+ organ systems or body areas)
 - Three Constitutional Signs = One Organ System

The June 2000 Draft DGs

Physical Exam:

- Single system examinations - specialty specific vignettes developed in conjunction with specialty societies
 - for each level of service
 - emphasizing commonly seen patients/conditions - examination tailored to the problem

The June 2000 Draft DGs

Physical Exam:

- appropriate examination vignettes will assure accurate assignment for level of examination
- will reflect the most commonly performed examinations
- will not involve counting
- will have work equivalence validated

The June 2000 Draft DGs

Possible Scenarios:

Cardiology/Internal Medicine

Typical follow up: Stable CHF, CAD - vital signs, neck vessels, cardiac auscultation, pulmonary auscultation, peripheral edema =
Brief (corresponds to two organ systems)

- Generalize to similar conditions?

The June 2000 Draft DGs

Neurology:

F/U stable headache: vital signs, Cranial Nerves, TMJ, sinus = Brief

F/U worsening peripheral neuropathy: vital signs, sensorimotor exam all four extremities, cranial nerves, cerebellar/cortical function = Detailed

The June 2000 Draft DGs

Orthopedics/IM/FP/Rheumatology/NS

NP Low Back Pain - VS, abdominal exam, neuromuscular examination of the back, groin, and LE's = Detailed

F/U Low Back Pain - VS, focused exam of back, LE's based on previous exam = Brief

The June 2000 Draft DGs

Medical Decision Making:

- Simple Table - 3 factors - severity/urgency of illness, differential diagnosis/data review, and treatment plan
- Three levels - low, moderate, high
- Two of the three factors must meet the requirements for the type of decision making in order to qualify

The June 2000 Draft DGs

- No lists of problems, tests, procedures
- Physician will refer to vignettes
- Specialty Specific Vignettes to be developed in conjunction with specialty societies
- Vignettes will emphasize commonly seen patients/problems
- Vignettes for each level of service

The June 2000 Draft DGs

- Vignettes may apply to more than one specialty (e.g CHF for FP, IM, CV)
- Single Problem may have several vignettes (e.g. Abdominal Pain GS, IM, FP etc.)
- Work equivalence validated
- A single vignette may be utilized for both examination and medical decision making

The June 2000 Draft DGs

Possible Scenarios:

IM/FP/Peds

URI - Hx/PE straightforward, no complicating factors = Low Urgency/Severity, Limited differential/data review, Straightforward treatment plan = Low level decision making

The June 2000 Draft DGs

IM/FP/Cardiology

F/U DM/HTN/CAD with worsening chest pain - extensive interval history, detailed physical examination = Moderate/High level urgency/severity, Limited differential/data review, Straightforward/Complicated treatment plan = Moderate level decision making

HCFA's Planned Studies

Study the draft DGs and vignettes in two ways:

- (1) Identical to Current Use: each key component given equal weight
- (2) Give extra weight to Medical Decision-Making - amount of extra weight not yet determined

Proposed Studies

- Both utilize the same draft DGs and the same vignettes
- Physician and reviewer education will differ for the two studies
- Medical Decision Making study will involve new approach to assigning a level of service for both physician and reviewer
- Medical Review on a post pay basis

Vignette Development

- Will start ASAP
- Independent Contractor
- Works with specialty societies
- Specialty Society develops vignette, other specialty societies review and validate vignette

Vignette Development

- Which patients? Which illnesses?
 - not yet determined
 - commonly seen problems could be determined from claims information
 - could base vignettes on actual medical records instead of hypothetical examples

Training

- Development of materials will start ASAP
- Training will begin after vignettes finalized
- Outside contractor will train physicians and reviewers and will work with physicians and reviewers to develop appropriate training material

Physician Participation

- National Contractor
- Representative Sample
- Voluntary Participation
- Multiple Specialties, multiple practice types
- Participation means all records will be reviewed according to draft DGs -
- Issue of providing immunity, protection, use of sterilized records is under review

Medical Review

- Through National Contractor or subcontracted to individual carriers - not yet determined
- Multiple Reviewers for **each** record: nonclinical, clinical nonphysician
- Physician Review: **subset** of all records

The Studies Themselves

- Will begin immediately after training
- Length to be determined
- Outside Contractor will design and implement
- Standardized score sheet for medical review
- Participating Physician feedback on the DGs will be obtained - method to be determined

Design of Studies

- Some of the remaining questions:
 - How many physicians need to participate?
 - How many records need to be reviewed?
How many records per physician?
 - What type of statistical oversight and analysis is required?
- Final Report

Changing the CPT Codes

- Obtain data on actual physician practice to inform HCFA and the AMA CPT Editorial Panel
- Analyze data to determine the most appropriate parameters to use for structuring and defining E/M services

Changing the CPT codes

- HCFA will begin working with an outside contractor this summer
- Will start with review and analysis of NAMCS database
- Will review other databases as appropriate
- Will use data from studies of the June 2000 draft DGs in this effort

Changing the CPT codes

- Final report on studies of draft DGs will include report on studies of NAMCS (and possibly other) database
- Final report will include recommendations to AMA CPT Editorial Panel on the structure and definitions of E/M services
- HCFA is committed to work with the AMA CPT Editorial Panel in this process

While the Studies are going on

- Until new DGs are implemented we are instructing our contractors to continue reviewing claims according to the 1995 and 1997 DGs, whichever is more favorable for the physician

Process

- HCFA is committed to an open process
- Information will be given at regular intervals to all interested parties
- Updates in monthly conference calls and other venues to be determined

Process

- This is not a Regulation
- We welcome and expect comments on all aspects of our proposals
- We will review all comments and modify our proposals as appropriate
- PPAC will play an important role in helping us review comments

Process

- PPAC meeting on September 11 will be devoted E/M -
- PPAC will review all comments received by August 11 and will hear oral testimony

Process

- Send comments to:

Mr. Terrence Kay, Director

Division of Practitioner and Ambulatory Care

PPG/CHPP

C4-02-06

7500 Security Boulevard

Baltimore, Maryland 21244

Process

We especially want comments on:

- the draft DGs
- development and use of vignettes
- physician and reviewer training
- the proposed studies
- volunteers/recruitment of physicians for the studies

Conclusion

We look forward to working with the physician community on developing new E/M DGs

We anticipate that this process will result in clinically appropriate DGs that reflect current standards for documentation and facilitate reliable, consistent medical review