

HCFA Status Report on Evaluation and Management Documentation Guidelines (June 2000)

Summary:

The purpose of this paper is to provide a report on the status of our work related to Documentation Guidelines (DGs) for Evaluation and Management (E/M) Services. We continue to believe that DGs are needed to assist physicians and medical reviewers in selecting the most appropriate level of E/M code that best reflects the service provided.

However, we agree with physicians that we need simpler, clearer documentation guidelines. Therefore, we have drafted a new version of the guidelines that are based on the 1995 DGs. We plan to further study these guidelines before implementing them, and we invite comments from physicians and others. Issues included in the paper are:

I. Goals for the Draft Documentation Guidelines (June 2000)

II. History of the E/M DGs

- A. Medicare Physician Fee Schedule
- B. Chronology
- C. General Concerns

III. Alternative Approaches

- A. Suggestions for Alternative Approaches
- B. Studies Completed to Support HCFA's Approach

IV. HCFA's Analysis

- A. Analysis of the Technical Assessments
- B. Analysis of the 1997 and Proposed 1999 DGs

V. HCFA's planned Approach

- A. Draft DGs
- B. Proposed Studies
- C. Summary of HCFA's Approach

I. Goals for the Draft Documentation Guidelines (June 2000)

Our primary goal is to develop and implement E/M DGs that are consistent with current standards for documentation within the physician community. We will require what is considered, by practicing physicians, to be clinically appropriate documentation in order to facilitate consistency of physician coding, improve reliability of medical review, facilitate accurate payment, and ensure work equivalency across specialties.

II. History of the E/M DGs

A. Medicare Physician Fee Schedule

Prior to 1992, Medicare payments for physician services were made under the reasonable charge system. Payments were based on the charging patterns of physicians. This system was inflationary and resulted in large, unjustifiable differences among types of services, geographic payment areas, and physician specialties. Recognizing this, the Congress in the Omnibus Budget Reconciliation Act (OBRA) of 1989 added section 1848 to the Social Security Act. This section replaced the reasonable charge system with the Medicare physician fee schedule effective January 1, 1992. Section 1848 requires that each of the over 7,000 services paid under the physician fee schedule be divided into 3 components-- physician work, practice expenses (rent, employee wages, medical equipment and supplies, utilities, etc.), and malpractice insurance.

The intent of the OBRA provision was to create a fee schedule that reflects the relative resources required for performing physician services. Under the previous charge-based system, physicians in different parts of the country and specialties often used the same codes to bill for visits and other E/M services that varied greatly in the amount of work required to perform the service. Codes were often interpreted differently among specialties. The law, however, specifically prohibits any specialty payment differential. Thus, with the implementation of the resource-based system, it was necessary to change the coding system used for billing E/M services to more accurately reflect differences in physician work. The American Medical Association (AMA) Current Procedural Terminology (CPT) Editorial Panel implemented new E/M codes for 1992. In this context, HCFA and many physicians felt that DGs would be useful to supplement the CPT definitions to ensure that E/M codes submitted on claims reflected the physician work that was provided.

E/M services represent about 18 billion dollars in Medicare spending, accounting for about 40 percent of spending for physician services. As stewards of the Medicare program, HCFA is responsible for assuring that the payments we make on behalf of our beneficiaries are for medically necessary and appropriate services, and that the payments are appropriate for the services actually

provided. As part of that effort, each year for the past four years the Office of Inspector General (OIG) has completed a review of Medicare fee-for-service payments to estimate the extent to which payments are made that do not comply with Medicare laws and regulations.

Four years ago, the OIG found 14 percent of Medicare dollars were incorrectly paid. In fiscal year 1999 we saw that rate fall to less than 8 percent, and we sustained that improvement this year. This proves that we have made real progress, but also demonstrates that we still have more work to do, particularly in the area of ensuring that documentation for physician claims is adequate.

The OIG reported that improper payments to physicians accounted for 22 percent or 3 billion dollars of the total improper Medicare payments in fiscal year 1999. The OIG found that incorrect coding is an important cause of improper payments to physicians, especially for E/M services. Therefore, HCFA will be focusing this year on payments for two CPT codes used to report E/M services—99214 (office visit, established patient, level 4) and 99233 (inpatient hospital visit, subsequent care, level 3).

The DGs should result in fairer payment among physicians because of the sustainable growth rate (SGR) system, which is used to establish the annual update to the physician fee schedule. The SGR was established by the Balanced Budget Act of 1997 (BBA) and revised by the Balanced Budget Refinement Act of 1999 (BBRA). These Acts specify the formula for establishing yearly targets for physicians' services under Medicare. The use of SGR targets is intended to control the actual growth in aggregate Medicare expenditures for physician services. The annual physician fee schedule update is adjusted to reflect the success or failure in meeting the target. Therefore, incorrect coding by some physicians that leads to higher total Medicare physician spending penalizes physicians who code correctly, because under the SGR higher total expenditures result in an update reduction for all physicians.

B. Chronology

The AMA's CPT coding system was adopted by the Department of Health and Human Services (DHHS) for the reporting of physicians' services prior to implementation of the physician fee schedule. In conjunction with the development of the resource-based relative value scale for physician work, the AMA CPT Editorial Panel developed new CPT codes for E/M services. In 1992, concurrent with the implementation of the Medicare fee schedule, the CPT Editorial Panel adopted these new codes for E/M services. These new codes represented significant changes for the CPT coding system. Because these codes needed to reflect the relative work of different E/M services and needed to ensure work equivalence across specialties for each level of service, great emphasis was placed on their structure and their definitions.

In the transition to the resource-based fee schedule, the AMA CPT Editorial Panel reexamined the existing CPT structure for E/M services and restructured the number of levels of service for a given type of visit. They created five levels of service for some types of visits (outpatient visits and initial consultations) and three levels of service for others (inpatient visits).

Determining what constituted the work of an E/M service was not easy. Although numerous studies showed a significant correlation between work and time, it proved extremely difficult to translate that statistical fact into workable CPT code definitions. Therefore, after a great deal of consideration the CPT Editorial Panel defined the key components of an E/M service to be patient history, physical examination, and medical decision making. Typical times for each E/M service were provided by CPT, but for guidance only. Time was considered the key component only for those E/M services devoted to counseling.

Properly describing the relative work of each level of service was accomplished by describing the amount of history, physical examination, and medical decision making required for each level of service (e.g., problem-focused history, detailed examination, low complexity medical decision making, etc.).

HCFA and many physicians felt that the CPT definitions alone were insufficient to ensure consistent coding by physicians and reliable medical review. Therefore, HCFA began work with the AMA to develop DGs to supplement and clarify the definitions of E/M services contained in the CPT book (e.g., what are the requirements of an expanded problem focused examination, what are the requirements for moderate complexity medical decision making). HCFA distributed these DGs in September 1994 to Medicare carriers who began educating physicians on the appropriate use of the guidelines. The educational period concluded August 31, 1995. Effective September 1, 1995, these DGs were used for medical review of E/M codes. These initial DGs have subsequently been referred to as the "1995 DGs."

Some specialists criticized the 1995 DGs because the requirements for a complete single system examination were not clear. They felt that medical reviewers rarely gave credit for complete single system exams and, therefore, were not allowing specialists to meet the documentation requirements for high level E/M services. Moreover, it was difficult to ensure work equivalency between multi and single system exams under these guidelines. In response to these criticisms, HCFA and the AMA, with input from medical specialty societies, developed an alternative set of DGs that was intended to be more useful for single system exams. The alternative set of DGs included ten single system examinations. The definitions for the multi-system examinations were also clarified, and other changes were made. For instance, the required elements in

the medical decision-making algorithm were significantly changed. The revised guidelines were reviewed extensively and approved by representatives of most national medical societies. These revised DGs were released in 1997 and have subsequently been referred to as the “1997 DGs.”

Our original intent was to replace the 1995 DGs with the 1997 DGs. However, many practicing physicians strongly objected to the 1997 DGs because they felt that they were too complicated and would detract from patient care. Therefore, in April 1998, HCFA instructed Medicare carriers to use both the 1995 and 1997 DGs when reviewing records. Physicians could use whichever set of guidelines was most advantageous. Further, HCFA committed to look at alternative sets of guidelines, conduct pilot studies of any further draft guidelines before implementation, and to engage in extensive efforts to educate physicians and carriers on the requirements of the guidelines prior to implementation.

Also in April 1998, responding to widespread criticism of the complicated requirements for documenting a physical examination in the 1997 DGs, the CPT Editorial Panel drafted a simplified version of the 1997 DGs, called the “new framework”. At that time HCFA stated that the new framework would serve as a starting point for the development of new DGs. Nevertheless, in June 1998, the AMA’s House of Delegates passed a resolution opposing any documentation system that requires quantitative formulas or assigns numeric values to elements in the medical record. The House of Delegates also passed a resolution requiring the AMA to continue working with HCFA to develop simplified E/M DGs. Based on these resolutions, the AMA limited their involvement in the development of DGs to assisting HCFA in a technical capacity through the AMA CPT Editorial Panel.

The AMA CPT Editorial Panel completed its technical advisory work in June 1999 when it transmitted draft guidelines to HCFA. For purposes of this paper we refer to them as the “proposed 1999 DGs”. The proposed 1999 DGs, which used the new framework as a starting point, are a further simplification of the 1997 DGs. The 1999 DGs created an extensive list of possible elements of a physical examination and based its documentation requirements on how many elements from the list were performed. The proposed 1999 DGs also changed the requirements for documenting medical decision making. The CPT Editorial Panel noted, in its cover letter, that it could not “warrant” work equivalence among specialties for single system examinations. The panel further emphasized that the “qualitative” CPT definition of each type of examination should be given greater weight than the “quantitative evaluation of elements.” The proposed 1999 DGs have not been tested or systematically reviewed by the AMA. We agreed to review them as part of our commitment to reassess the DGs.

C. General Concerns

As discussed above, practicing physicians have expressed a variety of concerns about the current DGs:

- The DGs require more documentation than is clinically appropriate or necessary;
- Complying with the DGs can be burdensome and time consuming; and
- The physical exams contained in the 1997 DGs were confusing and too complicated, and require extensive counting of services and other elements.

HCFA agrees that any DG system should minimize such adverse side effects. In addition, HCFA agrees that the medical record should remain primarily a tool for clinical care. We are, also, concerned that the 1997 documentation requirements are creating an incentive to perform unnecessary services or document clinically irrelevant information for the sole purpose of being able to support a higher level of service. Such behavior can make the medical record clinically less useful and causes physicians to waste time reading useless information while searching for the relevant information.

III. Alternative Approaches

A. Suggestions for Alternative Approaches

We have received a wide range of suggestions either for revising the DGs or for making other related changes, including:

- Adopt the proposed 1999 DGs received from the AMA CPT Editorial Panel, with possible modification, based on HCFA's technical assessment.
- Modifying the 1995 guidelines and incorporating vignettes to further assist physicians and reviewers in determining appropriate levels of service for billing purposes.
- Increasing emphasis on the medical decision-making component of the guidelines.
- Minimizing documentation requirements altogether and focusing on peer review of outliers.
- Developing specialty specific DGs, such as age specific guidelines for children and adolescents.

We have also received a variety of other suggestions that would require altering the basic structure of the CPT E/M coding system. For example, some have suggested that it could be desirable to revise the current E/M codes by either collapsing the current five levels of service codes into three levels, or by including time more explicitly as a factor in determining the level of the code. Although we agree that it might be desirable to modify the current code definitions, HCFA believes that jurisdiction for considering basic changes to the CPT structure and descriptions lies properly within the AMA CPT Editorial Panel. We look forward to assisting in this effort and below we propose a process for beginning this reevaluation. In addition, we received other comments, which we are not addressing in this paper, because they involve issues about the medical review process, such as performing computer-assisted medical reviews.

B. Studies Completed to Support HCFA's Approach

HCFA continues to take concerns about the DGs seriously and has been considering alternative ways to address these concerns. In order to make an informed decision about which sets of guidelines to study prior to replacing the current DGs, we conducted the following technical assessments:

1. Technical Assessment of the AMA CPT Editorial Panel Proposed 1999 DGs

We contracted with a Medicare contractor, Trailblazer Health Enterprises, LLC, to conduct a technical assessment of (1) the effect of the three sets of guidelines (1995, 1997, and the proposed 1999 DGs) on the assigned level of service, and (2) the variation in assigned level of service by reviewers. Trailblazer selected a random sample from the E/M services previously reviewed during the 1998 random audit of E/M services. Of this sample, claims for the following codes were retrieved: 99201- 99205, 99212-99215, and 99231-99233. A registered record analyst reviewed all records, and a carrier medical director reviewed a sample of those same records. Each record was reviewed under the 1995, 1997, and the proposed 1999 DGs to compare code levels resulting from the use of each set of DGs.

Results:

Assigned level of service – The non-physician reviewer assigned a lower level of service to claims when using the 1997 DGs than when using the 1995 DGs or the proposed 1999 DGs. The physician reviewer assigned a higher level of service to claims when using the proposed 1999 DGs than when using the 1995 or 1997 DGs. Additionally, for the physician reviewer, there was a significant increase in the variation of the assigned level of service when using the proposed 1999 DGs but not

when using the 1995 or 1997 DGs. Assigned levels of service never differed from the billed level of service by more than one level.

Variation in assigned level of service by reviewer – The variation of the assigned level of service between the two reviewers was significantly greater when they used the proposed 1999 DGs as compared to when they used the 1995 and 1997 DGs. Much of the variation in assigned level of service between the two reviewers was because of differences in the evaluation of the medical decision-making component of the proposed 1999 DGs.

2. Technical Assessment of Physician Outliers

A second study also conducted by Trailblazer looked at whether medical review of physician outliers varied based on the documentation guidelines used. For this study the contractor compared the 1995 and 1997 DGs only. To select records for the study, the contractor identified a sample of family practitioners and internists who tended to bill a much higher proportion of level 4 and 5 E/M services than their peers. An independent coding consultant reviewed a sample of their level 4 and 5 claims to determine whether each of these claims should be paid, denied, or reduced to a lower level of service.

Results:

As discussed above, the claims reviewed in this study were from physicians submitting an unusually high proportion of level 4 and 5 services. Of the records reviewed, 40% were denied, 57% were assigned a lower level of service, and 1.4% were assigned the billed level of service. The rate of denial and assignment of a lower level of service was similar for both sets of guidelines. However, among the claims assigned a lower level of service, use of the 1997 guidelines resulted in more of those claims being assigned two levels of service lower than the level billed (24% vs. 14%).

IV. HCFA's Analysis

A. Analysis of the Technical Assessments

In general, we believe the results of the technical assessments suggest that the 1995 DGs result in more consistent, reliable medical review than the 1997 DGs or the proposed 1999 DGs. Below we address the implications for the DGs of the suggestion that the level of service assigned by the reviewer will frequently be only one level different from the level billed.

Because much of the variation between reviewers was because of differences in the evaluation of the medical decision-making component we feel that great emphasis needs to be placed on the DGs for medical decision making.

The technical assessment of physician outliers strongly suggests that records from these physicians will fail to meet the requirements of any set of reasonable DGs. Although medical review must target outliers, we believe that DGs will play a significant role in assuring proper adjudication of claims and correct payment for physicians with typical billing patterns.

We believe our technical assessments support the view that burdensome DGs, with excessive documentation requirements are unnecessary. However they reinforce the notion that DGs must reliably distinguish each level of service and that careful attention must be paid to the medical decision-making component of the DGs.

B. Analysis of the 1997 and Proposed 1999 DGs

1. Work Equivalency

Our own analysis of the proposed 1999 DGs has reinforced the concerns we share with the AMA CPT Editorial Panel that the proposed 1999 DGs are not work equivalent across specialties for a given level of service. Specifically we are concerned with specialty- specific examinations and the medical decision-making table. Moreover, because the 1997 DGs also employ quantitative evaluation of elements, we have similar concerns with the 1997 DGs. This is an extremely important concern, because the law does not allow specialty differentials.

2. Deviation from the CPT Definitions

We also believe that the proposed 1999 DGs, and to a lesser extent, the 1997 DGs, deviate significantly from the qualitative CPT definitions for examinations and medical decision making. We are concerned that it is possible to satisfy the numerical requirements for a physical examination while not meeting the qualitative requirements of the CPT definition to examine affected body areas or organ systems. Breaking the physical examination down into a list of elements and then requiring documentation of a subset of those elements to achieve a level of service creates an unacceptable incentive to perform unnecessary examinations and to record clinically irrelevant information.

Furthermore, the medical decision-making tables for the 1997 DGs and the proposed 1999 DGs deviate from the CPT definition of medical decision making. First, the factors that comprise medical decision making, such as patient risk and amount of data to be reviewed, are significantly rearranged

or altered. Second, the list of examples for each factor is confusing, rigid, and frequently will be clinically irrelevant to the physician and reviewer attempting to assign a level of service to a visit. Third, the assigned level of decision making is determined by only a single factor in the decision-making process.

We believe that these deviations from the CPT definitions are one source of the confusion and concern generated over the 1997 DGs. Also, we are concerned that these deviations from the CPT definitions will occur with any DGs that rely on counting or on complicated formulae to determine the extent of a physical examination or medical decision making. Therefore, we believe that implementation of such DGs will lead to continued confusion for both physicians and reviewers.

3. Conclusion

a) The foregoing analyses support the notion that some of the problems attributed to the DGs are really attributable to the structure and descriptors of the CPT E/M services. We would support an effort to revisit the current CPT structure and descriptors.

b) Any counting in the DGs should be minimized and, if needed, should be restricted to areas where it reflects clinically relevant care. Counting should not create an incentive to provide or document unnecessary care.

c) An accurate and reliable method, other than counting, for assigning a level of service to a claim and for distinguishing between levels of service needs to be developed

d) We are not planning further study of the 1997 and 1999 DGs. We have made this decision despite our initial thought that the new framework guidelines developed in 1998 could be the starting point for developing new DGs. Our analysis suggests that implementation of the proposed 1999 DGs will not address our concerns or the concerns of practicing physicians.

V. HCFA's Planned Approach

A. Draft DGs

HCFA is committed to continuing use of the current CPT structure and descriptions for E/M services because Medicare and other payers currently recognize and make payments on the basis of these codes. We believe it would create a great deal of

confusion if our revisions to the guidelines did not parallel the existing CPT descriptors. Therefore, we are continuing to use history, physical examination, and medical decision-making as the key elements for determining the level of service (or time when the visit is for counseling).

HCFA has drafted new DGs based on the 1995 DGs. For purposes of this paper, we refer to these draft DGs as the “June 2000 DGs.” (See Appendix 1 for a side-by-side comparison of the draft June 2000 DGs to the 1995 and 1997 DGs.)

HCFA recognizes that the primary work product of physicians is clinical care, not documentation. We want the new DGs to reflect that view. In revising the DGs, we have made an effort to make them clinically appropriate and to reflect current standards for documentation among practicing physicians. Although the draft June 2000 DGs are consistent with the basic structure of the original 1995 DGs and track the CPT definitions for the key components of an E/M service, we have simplified and clarified them. We have clarified the requirements for the history-taking component, and have emphasized the history of present illness for follow-up patients, for patients on multiple medications, and for patients requiring medication management. We minimize counting for all components of the guidelines and eliminate all references to shaded systems and bullets. We emphasize the clinically relevant documentation of “organ systems” in both the review of systems and the physical examination. The only counting required is the total number of organ systems evaluated in the review of systems and physical examination. There are no lists of individual elements. For the physical exam and decision-making components, we reduce the four levels of decision making to three levels. The medical decision-making component emphasizes documentation of clinically relevant medical decision making, such as severity and complexity of the patient’s illness, and the treatment plan.

As an important element in the draft DGs, we plan to develop specialty-specific vignettes for multi-system exams, single system exams, and medical decision making to be used as guides for the physician to tailor his/her personal documentation to the exam findings, assessment, and plan of treatment. Vignettes will be developed for all levels of service and will consist of conditions commonly encountered by physicians in a wide variety of specialties. Appropriate vignettes will be crucial for physicians and reviewers to accurately assign a level of service to a claim.

B. Proposed Studies

Our first study will utilize the draft June 2000 DGs with assignment of the level of service based on giving equal weight to each key component of the service. This is identical to the way the current E/M DGs are used by physicians and reviewers.

Our second study will assign different weights to each component of the visit for

the purpose of assigning a level of service. Specifically, we plan to explore an approach some have suggested in which we would emphasize medical decision making as the most heavily weighted component of the visit. We have not determined the exact weighting of the medical decision-making component and we welcome comments to assist us in designing this study. One approach we have considered would have both the physician and the reviewer assign an initial level of service based on the medical decision-making component. For families of codes with three levels of service this would also be the final level of service, such as level 1 for low level decision making, level 2 for moderate level decision-making, etc. For families of codes with five levels of service, such as an outpatient visit, a final level of service would be assigned after incorporating the weights for the history and physical examination. For example, a visit with high level decision making would be assigned an initial level of 4 or 5 and a final level 5 only if both the history and physical examination were comprehensive; otherwise, it would be level 4.

The medical review process used for these studies will incorporate and compare review by non-clinicians, non-physician clinicians, and physicians. One proposal is to have non-physician reviewers review all claims and physician reviewers review a subset of all claims or a subset of claims that were denied or assigned a level of service lower level than that billed by the physician.

In summary, we plan to do two studies of the draft June 2000 DGs. The first will weight each key component equally and the second will assign significantly greater weight to the medical decision-making component of the DGs. Both studies would utilize specialty specific vignettes to assist physicians and reviewers in assigning a level of service.

During the study period and until new DGs are implemented, contractors will be instructed to continue review of medical records according to the 1995 and 1997 DGs using whichever DGs are more beneficial to the physician.

Although development and implementation of revised DGs utilizing the current CPT structure and descriptors is a major step forward, we believe that a satisfactory resolution to physician concerns about the E/M guidelines may ultimately require revisions to both the structure and descriptors of codes for E/M services. In our view, many of the problems attributed to the guidelines actually result from the structure and descriptors of the codes themselves. In retrospect, these problems, in part, are likely related to the limited work done to validate the current structure of E/M services. Thus, the revised DGs discussed above are just the first step in what we see as a multi-step process to address physician concerns raised by the structure and descriptors of E/M codes and the guidelines developed to document E/M services.

C. Summary of HCFA's Approach

1. Develop, test, and implement revised guidelines within the current CPT structure of E/M services.

We plan to award a contract to assist us in developing vignettes to supplement our draft June 2000 DGs, and in designing and implementing studies of the draft June 2000 DGs. The contractor will work closely with practicing physicians and physician groups to perform these tasks. We expect that initial studies will be completed by the spring of 2001, with an evaluation of the draft June 2000 DGs completed by July 2001. This would allow for revised DGs to be implemented nationally, depending on outcomes of the analysis, by January 2002. In the intervening period, HCFA would further refine the training approach and materials used to implement revised DGs.

We will seek physician advice throughout the process of implementing revised guidelines. Most importantly, we want physicians to tell us whether the revisions being tested are, in fact, better for them in their day-to-day clinical practices. If test results demonstrate that further work is needed, we will make further adjustments. We welcome comments on the draft June 2000 DGs and on the studies we are planning. Written comments may be addressed to:

Mr. Terrence Kay, Director
Division of Practitioner and Ambulatory Care
PPG/CHPP
C4-02-06
7500 Security Boulevard
Baltimore, Maryland 21244

(See Appendix 2 for further information.)

2. Develop education materials based on the revised guidelines, and implement an educational campaign for physicians and reviewers.

Using the draft June 2000 DGs, we will develop educational materials for the physicians and reviewers who participate in our studies. Once the studies are completed and the guidelines finalized, we will update the materials as necessary in preparation for informing and helping to train physicians and reviewers on a national basis. For this national educational effort, we will work broadly within the agency, including such groups as the Division of Provider Education and Training, the Practicing Physicians Advisory Council, the Physicians' Regulatory Issues Team and

the Office of Professional Relations. In particular, HCFA's Program Integrity Group is beginning two innovative projects that examine the interaction of physicians with Medicare carriers, assess their education and service needs, and then develop programs and materials to address these needs. We will work closely with them in the course of the above studies and implementation, and collaborate as possible.

We will also monitor the type of inquiries/problems that physicians report to the carriers and experience with billing and payment. If these arise, we will develop further educational tools (or respond with refinements, as appropriate).

3. Work with the medical community to develop and implement, as appropriate, new descriptors and/or a new structure for reporting E/M services.

HCFA is considering ways to collect data to support a broader review of the codes for E/M services. For example, we plan to perform a detailed analysis of the National Ambulatory Medical Care Survey (NAMCS) data for 1992, 1997, and 1998. The NAMCS database captures a variety of information about outpatient visits and procedures. The data elements include the reason for the visit, the type of visit (new, established, consultation), physician specialty, patient age, ICD-9 diagnoses, medications, and face-to-face time spent with the physician. This analysis will include a determination of specialty-specific office visit distribution according to time, type of visit, age of patient, etc.

APPENDIX 2-- Planned Studies of Draft June 2000 DGs for Evaluation and Management Services (E/M)

We plan to perform two studies to help us determine what set of E/M DGs will replace the current DGs. Both approaches involve use of our draft June 2000 DGs and are described below.

We plan to address the following questions during the studies:

- Are the DGs less burdensome?
- What additional improvements are needed?
- Do physicians and practitioners believe the DGs reflect actual care provided?
- Do DGs help support accurate and appropriate billing across services?
- Do DGs reflect work equivalency across specialty evaluations and general multi-system evaluations?
- Do DGs help reviewers to accurately and consistently determine what care was provided?
- Is there a difference in the distribution of coding levels resulting from the use of the DGs?
- Are the methods to train providers and reviewers effective?
- Does the type of training affect coding?

A. Study giving equal weight to each component of the E/M service (history, exam, and medical decision making)

We will train physicians and reviewers participating in the study to use the draft June 2000 DGs to assign a code level to E/M services. As discussed elsewhere, these draft DGs are based on the current 1995 DGs. In this study, consistent with current practices, each of the three key components of a visit (history, physical examination, and medical decision making) will be weighted equally in determining the level of service. As is currently required for new patient visits, all three key components must meet or exceed the documentation requirements for that level. For established patients, two of the three key components must meet or exceed the documentation requirements for that level of service.

B. Study placing emphasis on the medical decision-making component of the E/M service

This study uses the same draft June 2000 DGs and vignettes used in the first study for physicians and reviewers to assign a code level to the service provided. However, in this study, the three key components (history, physical examination, and medical decision making) will not be weighted equally. The medical decision-making component will be weighted more heavily than the other two components. There are many different ways to do this. We propose the weighting discussed below for the purposes of this study.

In assigning a level of service, both the physician and the reviewer will first make a preliminary determination of the possible range of the level of service. This will be based solely on the medical decision-making component of the draft June 2000 DGs. This determination will be made after reviewing the DGs and the applicable medical decision-making vignettes. For visits with five levels of service, (e.g., established office visits):

- a visit requiring low-level decision making could be assigned level 1, 2, or 3,
- a visit requiring moderate-level decision making could be assigned level 3 or 4, and
- a visit requiring high-level decision making could be assigned level 4 or 5.

After this preliminary determination is made, both the physician submitting a claim and the medical reviewer will make a final determination of the code level based on the history and physical examination components of the June, 2000 DGs. Both of these components must meet the requirements of level 5 in order for the final level of service assigned to be level 5.

For example, for an office visit requiring high-level decision making, the final level of service could range from a level 4 to a level 5. If the history and physical examination components meet the current CPT requirements for level 5, then level 5 would be assigned. If these components do not meet the requirements for level 5, then level 4 would be assigned. The final level of service could not be less than level 4.

The method of assigning a level of service for this study differs from the method currently in use and from the method in the other study. Training for physicians and reviewers participating in this study will be different from the training for the other study. We understand that conceptually the documentation requirements for this study are different from the requirements physicians have been using since the initiation of the current E/M codes. However, we believe that medical decision making may represent the most important component of an E/M service and we believe that weighting medical decision making more heavily than the other key components of an E/M service may more accurately reflect the work of an E/M service.

C. Contractor Support

We will obtain contractor support for the full range of activities related to revising the current DGs. The following is a summary of the planned activities.

DEVELOPMENT PHASE

- Solicit/develop, compile, and refine specialty-specific vignettes to use with documentation guidelines.

DESIGN PHASE

- Design the study sampling methods.
- Design methods compilation, recording, and analysis of data.
- Develop ways to assess reactions of physicians to the alternative DGs.

TRAINING PHASE

- Develop training material and conduct training for participating physicians and medical reviewers

STUDY PHASE

- Train physician/provider participants.
- Collect and review claims using the new guidelines.

REPORTING & EVALUATION PHASE

- Compile and analyze study results and public comments regarding the various approaches.

IMPLEMENTATION PHASE

- National training of physicians and reviewers
- Assist HCFA on implementation of final DGs
- Track/monitor for problems or issues, and address as appropriate