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On

Evaluation and Management Documentation Guidelines

Presented to the

Practicing Physicians Advisory Council

By

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AAMC Statement by Albert Bothe Jr., M.D. to the Practicing Physicians Advisory Council
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Good morning, Mr. Chairman and members of PPAC. Thank you for the opportunity to address you on this important issue. I am Albert Bothe Jr., M.D., Executive Director, University of Chicago Faculty Practice Plan, Compliance Officer and Professor of Clinical Surgery, University of Chicago, and Medical Director, University of Chicago Health Plan. I am also a member of the Association of American Medical Colleges' (AAMC) Group on Faculty Practice Steering Committee and Chair of the Steering Committee's Subcommittee on Legislative and Regulatory Issues. The AAMC represents the nation's 125 accredited medical schools, nearly 400 major teaching hospitals, more than 105,000 clinical and basic science faculty in 98 academic and scientific societies, and the nation's 66,000 medical students and 97,000 residents**.**

My remarks today will focus on three topics. First, I will discuss the interrelationship of issues faced by faculty physicians who work under both the E &M Documentation Guidelines and the so-called Teaching Physician Regulations. Second, I will discuss specific issues unique to the teaching setting, which we believe need explicit consideration within the conceptual frameworks implied by the public deliberations and discussions held to date**.** Finally, I will express our interest in having CMS, the Program Integrity Group and the Office of the Inspector General staff agree to interpretation and audit criteria for any proposed changes to the documentation guidelines or systems for identifying appropriate E & M codes.

I. Background

The medical record is a tool; it is a byproduct of the delivery of medical care. It is also the principal repository of information concerning past medical care. As such, it serves as a communication vehicle for and among providers to facilitate continuity of care.

Within academic medical centers, this communication functionality allows the medical record to serve also as a powerful teaching mechanism. The medical record can simultaneously provide an instructive chronology of disease progression and treatment, serve as a location where

caregivers can synthesize observations and request action, and become an essential component for quality improvement. From their own training experience, physicians know the critical role of the medical record in the teaching of medical students, residents and other members of the health care workforce.

To some, particularly with audit and oversight responsibility, the clinical uses of the record seem to have become of less concern than other uses. The medical record itself has become the default equivalent to medical care delivery. The use of the patient record for audit and oversight purposes has led to some of our current difficulties because of the overlay of a complex coding system and the associated documentation requirements that support reimbursement procedures.

The IOM and others have increasingly encouraged the adoption of electronic medical records, or EMRs, as a means to improve patient safety, support decision making, enhance quality assurance activities and promote outcomes research. Academic medical centers are on the forefront of adopting this technology. The impact of EMRs on the Teaching Physician Regulations has already been raised as a concern within our community. The potential impact on E & M documentation is of equal concern. We encourage awareness of the issues raised by this emerging technology as potential alternatives are considered**.**

II. Interrelationship of E&M Documentation Guidelines and the Teaching Physician Regulation

We support the development of a coding system that physicians can use to report their services while practicing medicine according to patient needs. In academic medical centers the practice of medicine also involves teaching the next generation of physicians and other members of the health care workforce. We appreciate the effort underway by CMS to address the specific regulations that impact teaching physicians through its review of Section 15016 of the Carrier Manual Instructions and look forward to the finalization of that review. We are hopeful that the forthcoming changes will decrease the burden of duplicative and unnecessary documentation requirements for teaching physicians.

As I mentioned, the nation's 88,000 clinical faculty must adhere to both the requirements of the Teaching Physician Regulations and the E & M Documentation Guidelines that impact all physicians. I would argue to avoid complex documentation requirements implemented on behalf of nonclinical users that would add additional burdens to patient care and educational tasks. And, in light of the goal of developing a system that allows physicians to practice medicine according to patient needs, it is important to note that duplication of activities by clinical care providers may often mean duplication of activities for patients, as well. These important considerations apply across all specialties and are particularly relevant for E&M codes**.**

With the changes in medical education at all levels, it is essential to avoid duplication of effort that is required because of training. An attending faculty member should not have to perform a largely clerical function to restate the components of care which a resident has already accurately recorded. There are important logistic issues that must be considered, but the current guidelines require an excessive amount of duplicate recording. We would strongly urge that any new system for E & M codes and related documentation guidelines be designed to minimize the need for documentation that is unrelated to clinical care delivery and that unintended additional documentation requirements in the teaching setting be avoided.

We would also encourage moving away from the current "counting methodology" as applied to the three key components: history, physical examination and medical decision making. The need to count "elements" or "bullets" sends the wrong message by emphasizing a distributive, number-tallying methodology. AAMC surveyed its constituents during various recent attempts to revise the E&M Documentation Guidelines and found widespread support for moving away from a system that requires a detailed numeric approach to characterizing medical care in these three key areas. Such an approach is no longer congruent with current medical conditions or practice. Patients are far more likely to present with multiple or chronic conditions than they are to present with a single illness, which is more amenable to "check lists." Even if the "counting" approach cannot be eliminated entirely, it can be greatly simplified by focusing on the components of medical care which make the most difference and are most relevant to medical decision making.

We endorse the seven principles put forth by the CPT Editorial Panel E & M Workgroup. I would like to suggest, however, that two additional principles may be helpful in future consideration of alternatives to the current E&M system. Any new approaches should (1) eliminate duplication of documentation in the teaching setting and (2) minimize or eliminate the current emphasis on "counting".

III. Considerations Relevant to the Teaching Setting

I would like to turn now to several factors specific to the teaching setting when considering new approaches to E&M coding. I understand that part of the discussion about revision of the coding system centers around the use of time to report physician services. If reporting of time were to become part of the solution, teaching physicians should not be penalized. The delivery of care in a teaching setting often requires additional time in order to fulfill both care and teaching requirements. In our current reimbursement system, the teaching component is occasionally recognized under the Part A methodology. Just as teaching physicians should not be reimbursed under Part B for this function, nor should they be inadvertently disadvantaged by a predominantly time-based system. Further, no physician should be inadvertently penalized for levels of expertise or efficiency which may allow him or her to be more productive than peers and thus perform medical services in less time than average. The current RUC methodology to account for time through surveys would seem able to address these concerns.

IV. Audit and Compliance Activities

My third and final comment relates to the implementation of any revised or new system in the future. As you are probably aware**,** the Health and Human Services Advisory Committee on Regulatory Reform recently recommended eliminating documentation guidelines for E & M services. While such an action undoubtedly has the potential for lessening a major regulatory burden for physicians, it could also potentially become a major new source of concern for physicians**.**

Many OIG audits have shown the problems faced by providers when clear interpretations of regulations were either not available or were not adequately distributed to physicians and providers. An example of particular relevance to the academic community on the need for adequate clarification was the Physicians at Teaching Hospitals (PATH) audits. Those audits made this community very sensitive to compliance concerns. We cannot overstate the importance of having a common understanding of Medicare's rules among CMS staff who interpret the law, Program Integrity Group and OIG staff who perform audits, and the physicians who are held accountable for following the government's rules. For example, during the PATH audits, some institutions found that letters of clarification they received from carriers and HCFA were deemed by the OIG to not comport with the correct interpretation of the regulations. Thus, such clarifying documentation, which were often the only sources of interpretation available to providers and assumed to be from an authoritative source, were useless in supporting an institution's activities to the OIG.

We are quite pleased to see that the Workgroup includes staff from the Program Integrity Group. We strongly urge that any proposed E & M system be thoroughly reviewed and agreed upon by all relevant sections of CMS, including the Program Integrity Group, and Office of the Inspector General staff prior to implementation. Furthermore, we believe that the process needs to go further by including a thorough pilot study of the new E & M system. The pilot should include all types of providers, including those at academic medical centers, and all components of the implementation and audit process (including carrier reviewers and OIG staff.) Adequate funding to conduct the pilot should be provided. Once a revised E & M system is piloted and finalized, comprehensive education must be provided to physicians and other health professionals and carrier staff and reviewers.

Attempts to modify and improve the E&M system demonstrate a good faith effort to address the current burden on physicians. The value of this effort will be diminished if there is a lack of clarity and consistency from CMS, Program Integrity Group and OIG staff.

V. Summary

In summary, we endorse the seven principles identified by the E & M Workgroup to date and suggest consideration of two other important concerns: the need to eliminate duplication of documentation and the need to minimize a "counting" approach within the system. Further, we ask that any consideration of systems that are time-based recognize the unique issues faced in a setting where faculty, residents and students are involved in patient care. Finally, we ask that the review and vetting of potential new systems include concurrence from Program Integrity Group and Office of the Inspector General staff on the interpretation and implementation of the E&M system in the context of compliance audits.

We thank PPAC for the opportunity to speak on this issue today and also thank the members of the CPT Editorial Panel E & M Workgroup for undertaking this task of critical importance to the physician community. In light of the special importance of this task to academic physicians, we offer our support in facilitating the inclusion of teaching physicians in any pilot activities and stand ready to provide other assistance that would be useful to the deliberations.

Summary of AAMC Statement

Interrelationship of E&M Documentation Guidelines and the Teaching Physician Regulation

Consider the addition of two new principles or review guidelines for any new approaches:

(1) eliminate duplication of documentation in the teaching setting and

(2) minimize or eliminate the current emphasis on "counting"

Revisions to the E & M coding system should be considered in light of emerging electronic medical record technology

Considerations Relevant to the Teaching Setting

Increased emphasis on time as a proxy for work should account for the involvement of residents in the teaching setting without penalizing teaching physicians

Increased emphasis on time as a proxy for work should not penalize expertise or efficiency that results in shorter visits

Audit and Compliance Activities

Interpretation of the E &M system in the context of compliance audits should be agreed upon by Program Integrity and Office of the Inspector General staff prior to implementation

Proposed systems should be thoroughly pilot tested and include various types of providers, including those at academic institutions; carrier reviewers, Program Integrity Group and OIG staff should be involved

Comprehensive education must be provided to physicians and other health professionals and carrier staff and reviewers.