



November 20, 2019

Seema Verma
Administrator
Centers for Medicare and Medicaid Services
Department of Health and Human Services
PO Box 8016
Baltimore, MD 21244-8013

Re: Center for Program Integrity Request for Information on Using Advanced Technology in Program Integrity

Dear Administrator Verma,

On behalf of the American College of Physicians (ACP), I am pleased to share our feedback on the Center for Program Integrity's Request for Information (RFI) on using advanced technology to improve the program. The College is the largest medical specialty organization and the second-largest physician group in the United States. ACP members include 159,000 internal medicine physicians (internists), related subspecialists, and medical students. Internal medicine physicians are specialists who apply scientific knowledge and clinical expertise to the diagnosis, treatment, and compassionate care of adults across the spectrum from health to complex illness.

General Program Integrity and Burden Reductions Comments

ACP appreciates and agrees with the Agency's stated goals of putting patients first and using innovative solutions to unburden physicians so they can focus on providing the best possible patient-centered care. We also understand the importance of maintaining program integrity and the need to safeguard federal resources to protect Medicare beneficiaries from fraudulent bad actors. While advanced technology provides an opportunity to improve program integrity efforts while also reducing physician burden, it is important to highlight that much of the administrative burden and complexity stems from the lack of transparency and variation in the numerous types of requirements across the U.S. health care system, including among payers and auditing contractors. Implementing technical solutions without addressing these underlying issues will likely not provide a less burdensome result. ACP continues to call for all health care stakeholders (including both public and private payers as well auditing contractors) who develop and implement administrative requirements to fully assess the underlying intent and impact these requirements have on the delivery of care.¹ Where requirements cannot be

¹ Erickson SM, Rockwern B, Koltov M, et al, for the Medical Practice and Quality Committee of the American College of Physicians. Putting Patients First by Reducing Administrative Tasks in Health Care: A Position Paper of the American College of Physicians. *Ann Intern Med.* 2017;166:659–661. doi: <https://doi.org/10.7326/M16-2697>

removed, stakeholders should work to align and streamline these requirements, including differences across auditing contractor's post-payment review.²

The College believes that CMS has demonstrated their commitment to putting patients first and reducing burden through their efforts to reduce clinical documentation requirements for Evaluation and Management (E/M) services. The policies to remove requirements for documenting history and physical exam to justify payment levels, as well as providing the option to document based on time *or* medical decision making (MDM), are an important first step. However, the College believes there are a number of critical next steps needed to operationalize these updates, including promoting consistent interpretation of what will actually be accepted for payment across all auditing organizations. The College is concerned that these updates will not be utilized due to fear of medical record review audits and financial penalty – resulting in the same lengthy and verbose notes. **ACP recommends³ CMS provide additional clarity, through rule-making or sub-regulatory guidance, on what will be accepted for both time-based and MDM-based documentation.** Useful clarification from CMS includes a clear understanding of what is needed within the note to qualify to bill a certain level of code (and whether data stored within other areas of the electronic health record [EHR] will qualify) – as well as a baseline for what will be considered clinically appropriate. In our comments on the 2020 Medicare Physician Fee Schedule proposed rule, ACP included the following clarifying questions for CMS's consideration:

- For time-based documentation, must the note itself include the time audit or meta-data features from the EHR? Alternatively, could the time-based note that includes a physician attestation of time and describes the data that exists in other sections of the EHR (without replicating it in the note) suffice?
- For MDM-based documentation, what will CMS accept as information within other sections of the EHR that could substantiate an MDM-suggested code level (without the need for physicians to manually click a box)?
- Will CMS permit EHR vendors to develop and build functionalities that capture both time-based and MDM-based requirements simultaneously? For example, a clinician cares for a patient and writes their note based on what is clinically important. Ideally, an EHR could indicate: “Based on your use of the EHR during the visit, this visit would qualify for a 99213 based on time OR a 99214 based on MDM. Click to choose or modify a note or attestation.”

ACP further recommends that CMS work to ensure that the auditing guidelines and procedures are updated and aligned to focus on both time-based and MDM-based notes – and applied consistently by all payers and auditing organizations. (*See Appendix for two documentation exemplars for a note based on time and MDM for CMS's consideration as they work to implement these important policy updates.*) This consistency will allow for advanced

² United States Government Accountability Office. Medicare program integrity: increasing consistency of contractor requirements may improve administrative efficiency. Report to Congressional requestors. July 2013. Accessed at <http://gao.gov/assets/660/656132.pdf>

³ ACP Comments on 2020 Medicare Physician Fee Schedule, Quality Payment Program, and other Medicare Part B Updates Proposed Rule: https://www.acponline.org/acp_policy/letters/acp_comments_proposed_2020_pfs-gpp_rule_september_2019.pdf

technologies like artificial intelligence (AI) and machine learning (ML) to further improve these processes, including more expeditious and accurate documentation review.

Feasibility and Use of AI and ML Record Review Tool Comments

With large technology companies interested and publicly committed to partnering with various health care organizations and health IT vendors, it seems that the capacity to develop and include AI/ML algorithms for medical record review in EHR workflows is increasing rapidly. However, the questions in this RFI allude to the need to assess the utility, effectiveness, cost, and potential risks of incorporating these tools into health IT. In order for these AI algorithms to function, there is a need to programmatically obtain more data for analysis. Even if the data elements needed for analysis are included within a subset of the U.S. Core Data for Interoperability (which health IT vendors are currently implementing in their systems to meet new ONC certification requirements), these data elements would likely provide limited utility for the AI technology to accurately determine whether the record meets a pattern or predicts what the proper claims payment should be.

Ideally, physicians and other clinicians could document the patient encounter based on their professional judgment and not the verbosity currently required by regulation, and the data and patterns of usage within the EHR could be reviewed behind the scenes and used to justify physician reimbursement. One potential approach to reach this ideal state, and expand the data available for AI analysis, could be to create application programming interfaces (APIs) to expose these patterns of EHR usage. These API use cases for medical record review would need to go through the consensus-based deliberative process facilitated by nationally recognized standards development organizations. Moreover, physicians may find these tools more useful if the technology provided information on how it reached the recommendation (e.g., list the variables considered within its recommendation for a proper/improper payment). Regarding cost of the technology, the College is concerned that only larger, well-resourced health systems will be able to afford these new technologies in the beginning, which may further separate reimbursement levels for these systems versus independent ambulatory practices.

Thank you for considering our comments as the Agency continues to assess burdensome processes and seeks to improve program integrity efforts. The College remains committed to working with CMS and other key stakeholders, including private payers, EHR vendors, clinician organizations, and patients, to challenge and reduce unnecessary practice burdens and re-invigorate the patient-physician relationship. Please contact Brooke Rockwern, MPH, Associate, Health IT Policy at brockwern@acponline.org if you have any questions or need additional information.

Sincerely,



Zeshan A. Rajput, MD, MS
Chair, Medical Informatics Committee
American College of Physicians

Appendix: ACP Documentation Exemplars for a Note Based on Time and MDM – Level 99214:

99214 Time-based Note	99214 MDM-based Note
<p>Pt returns for f/u of HTN and DM. Doing well, no new complaints. Taking meds regularly without SE or concerns. Diet – maintaining low simple sugar, low added salt.</p> <p>Wt. 165 lbs. BP 122/70 P – 72, reg. RR 14</p> <p>PE – unchanged from prior, except for tr ankle edema bilat</p> <p>Assessment – doing well, understands chronic conditions, diet, exercise, meds</p> <p>Spent additional time discussing how patient would not benefit from switching current healthy diet to a fad diet that was too high in saturated fats, including the additional risk of “yo-yo” weight loss.</p> <p>Plan – continue current regimens. F/U for in 4 mo., sooner if need be. Discussed and updated patient goals, spouse present for entirety of discussion.</p>	<p>Pt returns for f/u of HTN and DM. Doing well, no new complaints. Taking meds regularly without SE or concerns. Diet – maintaining low simple sugar, low added salt. Exercise – walking 4x/wk. about 30 min/day. No ED visits or hospitalizations since last visit. Other MD visits since last visit – cardiologist – no new diagnoses or meds.</p> <p>Wt. 165 lbs. BP 122/70 P – 72, reg. RR 14</p> <p>PE – unchanged from prior, except for tr ankle edema bilat</p> <p><i>Assessment – doing well, understands both chronic conditions, diet, exercise, meds including continued atenolol</i></p> <p>Plan – continue current regimens. F/U for in 4 mo., sooner if need be.</p>

Billing Options for Time-based Note:

Option #1: determined by physician attestation:

_ I attest I spent 32 minutes today on (include list of permitted activities), which includes face-to-face time with the patient.

Attestation time-based coding determination = 99214

Option #2: determined by EHR meta-data of 32 minutes:

EHR-calculated time-based coding determination = 99214

Option #3: determined by EHR meta-data of 27 minutes and physician attestation

EHR-calculated time-based coding determination = 99213

_ I attest I spent an additional 5 minutes talking with patient’s cardiologist (not including in EHR calculation) discussing use and dose of beta-blocker

EHR-calculated plus physician attestation time-based coding determination = 99214

Billing Options for MDM-based Note:

Option #1: as determined by 2 stable chronic illnesses and prescription drug management discussed in “Assessment”

MDM-based coding determination = 99214