September 7, 1999

Robert Berenson, MD, Director
Center for Health Plans and Providers
Health Care Financing Administration
Mailstop C5-24-04
7500 Security Boulevard
Baltimore MD 21244-1850

Dear Dr. Berenson:

On behalf of the American College of Physicians-American Society of Internal Medicine (ACP-ASIM), representing 115,000 physicians and medical students of internal medicine, I am writing to submit comments on the "new framework" for evaluation and management (E/M) documentation guidelines that have been submitted to the Health Care Financing Administration (HCFA) from the Current Procedural Terminology (CPT) Editorial Panel.

The new framework documentation guidelines are more reasonable than previous versions. However, we still find them to be overly complex and not consistent with typical clinical practice nor conducive to providing q uality patient care.

Recognize Documentation of Face-to-Face Patient Encounter Time

As you may know, ACP-ASIM supports a proposal to use patient encounter time and the "documentation basics" described in the new framework guidelines as an alternative to the new framework itself. ACP-ASIM encourages HCFA to pilot test such an approach. ACP-ASIM has studied this issue in-depth and concluded that physicians who code for E/M services themselves typically consider face-to-face patient encounter time as a surrogate for physician work. Moreover, the Harvard Hsaio study and Physician Payment Review Commission (PPRC) study demonstrated a very tight statistical correlation between the assessment of physician work and the intra-service time associated with providing an E/M service. Attached are journal articles describing these two studies. In addition, physicians are already familiar with such a documentation system, as it is used in documenting counseling and/or coordination of care.

ACP-ASIM is not suggesting that the new framework be completely replaced, but instead that a less complex, complementary system be pilot tested to see if it is a viable alternative to the new framework, which also must be pilot tested. The time-based alternative could be implemented in tandem with the new framework, giving the physician the option of using the documentation system of his/her choosing.

We strongly emphasize that HCFA, other payers, and other outside auditors should not abuse this proposal and turn it into a method of paying physicians by the hour or requiring us to carry stopwatches into the exam room—we do not want to be judged by such standards. Office schedules are not literal recording devices; they reflect the planned

patient arrival times but will never completely reflect the start and stop times of physician encounters.

Properly Credit Documentation of Negative Findings

ACP-ASIM urges HCFA to establish minimal documentation requirements so that there is no need to record the details of the negative systems review (non-changes in past medical history, family history, social history, and negative findings in physical examination). It is simply a waste of the patient's and his/her physician's time to document detailed negative findings. Such a system is a by-product of fraud enforcement, and not good patient care. Requiring physicians to document non-changes in medical history and detailed negative findings unnecessarily increases health care costs.

HCFA should approve a method of documenting examination negatives in which individual physicians develop a personal exam template that indicates what is included in each exam of an organ system. When the physician indicates that a certain organ system is found to be negative, the exam included multiple exam elements within the organ system. The doctor's signature on the note would serve as an attestation that each of those elements were performed. For example, Dr. Smith creates a personal exam template that indicates that her examination of the head/face/neck system includes the examination of items 1 (face), 2 (neck), 5 (thyroid), 8 (jugular veins), 9 (carotid arteries), and 10 (cervical lymphatics). If all elements were negative, she would simply have to indicate head/face/neck negative and would get credit for examining the 6 elements listed above. Individual physicians could create similar templates for each organ system. When an auditor reviewed the physician's charts, they would review the charts in conjunction with the physician's personal exam template to determine the individual exam elements performed.

Correct the Numerical Increments of Documenting Exam Elements

HCFA should consider changing the numerical increments for exam elements from 1-5, 6-11, 12-17, and over 18 to 1-4, 5-9, 10-14, and over 15. Such an ordering is much easier to remember and are more consistent with the increments for history.

Pilot Test the Guidelines

Proper implementation of the documentation guidelines is as important as their content. We are encouraged that HCFA is committed to pilot testing the guidelines. We believe that there are certain elements that must be included in any pilot test to accurately gauge whether the guidelines are reasonable and to ensure that they refrain from detracting from the time physicians need to spend on patient care. Any pilot test should:

- be conducted in multiple practice settings involving multiple specialties;
- be conducted in multiple geographic localities; and
- attempt to determine the amount of physician work and time involved in documenting according to the guidelines.

In addition, HCFA should allow all physicians who choose to use the new framework during the pilot test phase, not just those physicians who are participating in the pilot test.

Thank you for full consideration of these comments on the new framework for E/M documentation guidelines.

Sincerely,

Whitney W. Addington, MD, FACP
President

Attachments

Braun, P., et al, "Predicting the Work of Evaluation and Management Services", *Medical Care*, November 1992, Vol. 30, No. 11, Supplement, Pages NS13-NS27.

Lasker, R.D., and Marquis, M. S., "The Intensity of Physicians' Work in Patient Visits", *New England Journal of Medicine*, July 29, 1999, Vol. 341, No. 5., Pages 337-341.