The Next Generation of E/M Guidelines

Few non-clinical issues have inspired as much discussion, revision, and anxiety as the evaluation and management (E/M) services and their accompanying documentation guidelines. E/M services have produced a cottage industry focused on ensuring that medical records contain necessary documentation, templates are available to achieve it, and cheat sheets, score cards, tool kits, and more to verify it. Physicians, mid-level providers, and their staff hurry to E/M coding seminars in hopes of finally getting it right.

In response to the implementation of Medicare's Physician Fee Schedule, a complete restructuring of the codes used to describe patient visits was published in Current Procedural Terminology (CPT) in 1992. The goal of these new E/M services was to standardize the selection of codes across specialties and to better delineate differences in physician work. The selection of appropriate codes was based on defined categories, subcategories, and levels of service. It soon became apparent that additional guidance was needed to more clearly define the differences among levels of service and encourage consistent coding.

This guidance took the form of documentation guidelines (DGs) that have undergone numerous revisions since they were first published in 1994. In June 2000, the Health Care Financing Administration (HCFA), released yet another draft known as the "June 2000 DGs".

How Did We Get Here?

The first set of DGs was issued by HCFA in September 1994 and implemented for the review of medical claims on September 1, 1995. This set of guidelines, labeled the 1995 Documentation Guidelines, was the joint work of HCFA and the American Medical Association (AMA). It introduced the concept of "quantifying" certain aspects of medical documentation to determine levels of service. These guidelines defined a comprehensive examination as documentation of findings for at least eight different organ systems. Because of this, they were criticized for not reflecting the more focused work performed by specialists.

As a result, the 1997 Documentation Guidelines were developed as a cooperative effort between the HCFA, the AMA, and medical specialty societies. The intent was to provide single organ system examinations that reflected the clinical activities of specialists while maintaining work equivalency across all physicians. The result was a set of 10 single-system examinations and a multisystem exam. Documenting and "counting" the number of specific exam elements determined the level of examination. Clarifications also were made in the history and medical decision-making components.

This time, the concerns of the medical community focused on the complicated system for documenting the exam and translating the work into a level of service. Rather than adopting this as a replacement for the 1995 DGs, HCFA chose to delay implementation pending further review and revisions. In April 1998, it instructed its carriers to use both sets of the guidelines when reviewing medical claims. Physicians were given the option to select the set most appropriate to their practice.

At the same time, the CPT editorial panel drafted a revised version called the “New Framework”. It attempted to simplify the 1997 guidelines while continuing to quantify certain aspects of the medical record. Using input from the medical community, technical revisions to further simplify and clarify the guidelines were made and included in a document called “Proposed 1999 Documentation Guidelines”.

In keeping with its commitment to reassess the DGs, HCFA hired a contractor to perform a technical assessment of the guidelines. The purpose of the assessment was to compare the effect of the three sets of guidelines on the assignment of service levels and the variations among reviewers.

New Guidelines, Major Changes

HCFA concluded that a new set of guidelines was necessary to address the need for consistent medical record review and the concerns of the medical community. Thus, the June 2000 DGs were released. These Guidelines were developed by HCFA staff and are roughly based on the 1995 DGs. The CPT definitions of the key components are maintained; however, important differences distinguish this set of guidelines from previous versions.

Overall, an attempt has been made to minimize the counting for all components and to discourage the documentation of clinically unnecessary information. The most significant change is the inclusion of clinical vignettes that will serve as guides in distinguishing levels of service. Specialty-specific vignettes will be developed for all levels and will primarily address the exam and medical decision-making components. The vignettes will focus on commonly seen patients and conditions and will be central to the proper assignment of levels of service. Changes to key components of the medical record follow:

HISTORY

Changes in the history component will highlight medication monitoring and reduce the amount of documentation required for a complete system review. The type or level will continue to be determined by meeting or exceeding the requirements for all three elements of the history: HPI (history of present illness), ROS (review of systems) and PFSH (past, family, social history). Instructions to document efforts to obtain the history from multiple sources, further emphasizes the importance of this component in determining levels of service. Along the same vein, there is no provision for noting the inability to acquire the history. Rather, the guidelines comment on the rarity of this situation.

The HPI continues to be defined as either brief or extended, but is not restricted to a description of current symptoms. The types of HPI are distinguished by the amount of detail necessary to define the problem and may include comments about previously diagnosed problems or medication management.

The requirements for a complete ROS are reduced from documentation of ten systems to nine. However, the threshold for an extended review is increased from two to three systems. Therefore, the brief review now includes up to two systems. Negative findings do not have to be individually documented, but unlike previous versions, the name of each reviewed system must be specifically stated. Documentation of the PFSH is virtually unchanged from the 1995 guidelines.

EXAM

The types of physical exam are reduced from four to three and are classified as brief, detailed, or comprehensive. The number of body areas or organ systems assessed defines the exam. Seven body areas and eleven organ systems are recognized. Borrowing a concept from the 1997 Guidelines, a description of three constitutional findings (e.g., vital signs, general appearance) is analogous to one body area or organ system. The distinctions are determined as follows:

- **Brief**: findings from one to two defined organ systems/body areas
- **Detailed**: Findings from three to eight defined organ systems/body areas
- **Comprehensive**: Findings from at least nine defined organ systems/body areas

There are no specific exam elements associated with the organ systems or body areas. Neither is there a requirement for the extent of an individual system or area exam. Simple statements of "negative" or "normal" are sufficient to describe normal findings related to asymptomatic or unaffected systems and areas. Reference is made to the specialty-specific vignettes for appropriate documentation of single-system examinations.

MEDICAL DECISION MAKING

Low, moderate, and high define the types of medical decision-making. Although the concept for determining decision-making is unchanged, the elements have been reorganized. This new medical decision-making table includes three broad areas:

- Severity/urgency of illness
- Differential diagnosis and amount/complexity of data reviewed
- Treatment plan, including diagnostic and therapeutic tests, procedures, and interventions

The elements within each area are described simply by adjectives such as limited, complicated, and moderate. The specialty-specific vignettes are intended to provide guidance in using the table. As with previous versions, two of the three elements must either meet or exceed the requirements to qualify for a given type of decision-making.

TIME

The rules for using time as the controlling factor for the selection of the level of service remain. The total length of the encounter is the only time component that must be documented. Instructions now require that associated medical decision-making and references to any physical exam be noted.

Road-testing the Guidelines

Two studies are planned before the guidelines are officially released. The process will use physicians, other clinicians, and non-clinicians to review claims based on the June 2000 DGs. An outside contractor will assist in developing the clinical vignettes and the design and implementation of the study. Both studies will use specialty-specific vignettes to assist in assigning levels of service. The pilot testing is scheduled to begin this year with results available by summer of 2001. Implementation of the guidelines is not expected before January 2002.

The first study will place equal weight on each of the three key components. This is consistent with the current method of code selection. The second study will place greater emphasis on the medical decision-making area. Some physician groups have been long-standing proponents of

this approach. The assumption is that decision-making may be a better indicator of physician work than the extent of the history and exam.

A Future of Updates

Despite the analyses, revisions, and planned studies, the end may not yet be in sight. HCFA has indicated that the June 2000 DGs are only a first step in a multistep process to address concerns over the basic structure and descriptors of E/M codes. Suggestions have been made to reduce the number of outpatient levels of service and to make time a more integral component of the code descriptions. The ultimate decision regarding the structure of E/M codes, however, lies with the AMA CPT editorial panel.

With E/M services representing approximately $18 billion in Medicare expenditures, changes can be expected in the future.1 Coding expertise demands experience, continuing education, and constant updating of information. It is never too early to start preparing for the future.

Notes

[1] Presentation by Paul Rudolph, MD. Health Care Financing Administration Town Hall Meeting, June 22, 2000.

References

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