AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

April 23, 2018

Seema Verma, Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
200 Independence Avenue SW
Washington, DC 20201

Dear Administrator Verma,

On behalf of the American Academy of Family Physicians (AAFP), which represents 129,000 family physicians and medical students across the country, I write to offer further input on the questions asked by the Centers for Medicare & Medicaid Services (CMS) during the "Documentation Guidelines and Burden Reduction" listening session held on March 21, 2018. We greatly appreciate that CMS hosted this call and that the agency continues to engage stakeholders on potential updates to the Documentation Guidelines for Evaluation and Management (E/M) Services.

The AAFP wholeheartedly maintains that the CMS E/M documentation guidelines, established 20 years ago, do little to support patient care or improve quality. They are most commonly used to justify billing levels (e.g. level 3, 4, or 5) rather than help physicians diagnose, manage, and treat patients. Adherence to the guidelines consumes a significant amount of physician time and does not reflect the workflow of primary care physicians. CMS drafted these guidelines for use with paper-based medical records. Thus, they do not reflect the current use and further potential use of electronic health records (EHRs) or team-based care. They also negatively impact the usability of EHR software programs. In our study of "Meaningful Use" criteria, electronic documentation of the patient encounter was the most burdensome task. These guidelines also hinder interoperability by requiring the capture of clinically irrelevant information that is subsequently exchanged.

We offer the following feedback to the six questions posed by CMS during the listening session and look forward to working further with the agency toward improving E/M documentation requirements.

1. How can CMS reduce burden associated with documentation of patient E/M visits for billing?
The AAFP applauds CMS for recognizing the need to review and revise the 1995 and 1997 documentation guidelines for E/M services. Comprehensive reform of E/M documentation guidelines, and the E/M code set, should occur and be a collaborative effort among stakeholders. Reform should occur as rapidly as possible.

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We recommend CMS revise the guideline regarding recording review of systems and past, family, and social history to state: "The medical record may be recorded by any staff involved in the patient's care or by the patient, as appropriate. To document that the physician reviewed the information, there must be a notation supplementing or confirming the information recorded by others."

Furthermore, we urge CMS to revise section 3.3.2.1.1(B) of chapter 3 of the Medicare Program Integrity Manual to instruct review contractors to consider all medical record entries made by physicians and "other staff involved in the care of the patient, along with the patients themselves."

Whatever proposed solution CMS considers, it must not be one that merely replaces the current complex and administratively burdensome guidelines with another administratively burdensome set of guidelines.

2. What approaches to payment and documentation do others outside of Medicare, such as private insurers, use for E/M visits by level? How do they take into account issues like history, physical exam and body systems, medical decision-making, face-to-face clinical time, non face-to-face care, among other issues?
Our understanding is that most payers outside of Medicare, including private insurers, use an approach like Medicare's for payment and documentation of E/M services. We are aware that Anthem, a large national private insurer, adopted a policy to make medical decision-making (MDM) one of the two key elements when coding an established patient visit and subsequently retracted the policy in the summer of 2016 due to objections from physician groups including the AAFP. Instead, Anthem has underscored its position that MDM should align with the complexity of the patient's history and physical, and Anthem considers that position in the context of coding audits. We believe the Anthem experience provides a cautionary tale to CMS about taking a similar path in its efforts to revise the Medicare E/M documentation guidelines.

3. How much of a role should the currently required items (history, physical exam, and medical decision-making) play in supporting an E/M visit level for payment? What are the types of changes you would like to see made to each of these pieces? For example, what might be ways to change how medical decision-making is defined? Should CMS remove its requirements for recording history and physical exam, or should these requirements be reduced (if reduced, how)?
In general, the guidelines are a burden on family medicine that lacks an offsetting benefit to clinical care. The AAFP calls on CMS to address redundancies in documentation requirements to alleviate some of the burden. Documentation guidelines should align with clinical expectations and outcomes, but these guidelines are outdated. CMS drafted the guidelines for use with paper-based medical records; thus, the guidelines do not reflect the widespread use of EHRs. Furthermore, the guidelines are inconsistent with the current emphasis on team-based care. **Outdated E/M documentation guidelines and the Medicare Program Integrity Manual should be changed to allow medical information to be entered by any care team member related to a patient's visit**. This standard should be applied by all Medicare contractors, Medicaid, marketplace policies, and private payers. Current required elements such as past, family, and social history (PFSH), review

of systems, and unnecessary hands on physical examinations have the potential to degrade the patient-physician encounter to a “fill-in-the-blank” session rather than a medical treatment session.

Concerns within the medical decision making (MDM) section of CPT guidelines, as well as CMS guidelines, tend to place value on quantity of tests or procedures performed and/or reviewed, rather than the necessity and effectiveness of the outcomes or actions. The number of tests and procedures is easy to count, but evaluating the complexity of diagnoses, tests and procedures demands a better mechanism for uniform and meaningful documentation.

4. What are suggestions for updating documentation rules by changing the underlying E/M code set itself? For example, what might be ways to stratify visits or alternatives to the existing number and type of levels?
The AAFP agrees with the underlying premise of this question, which is that part of the problem with the E/M documentation guidelines is the underlying E/M code set itself. We believe that reform of the E/M code set should occur as rapidly as possible and be a collaborative effort for all stakeholders. In the meantime, CMS can work to make the current E/M documentation guidelines less onerous, and CMS should not let reform of the underlying E/M code set delay reform of the documentation guidelines as suggested above.

5. Some stakeholders have suggested that CMS should not require documentation if the information already exists in the patient’s medical record. Which of the three elements does this apply to most (i.e., which of the requirements involve duplicative re-entry of data that is already in the record)? Do stakeholders think this is a useful approach? How much burden would it relieve?
We agree with other stakeholders that redundancy in the medical record hinders the patient-physician relationship and reduces access to one of the most valuable resources in this relationship: time. According to the guidelines, the same information must be restated to count towards multiple elements of required documentation in such areas as history of present illness, review of systems, and past family and social history. These redundancies contribute little towards patient care and quality outcomes and such requirements should be eliminated.

6. Should there be any specialty-specific changes to the documentation guidelines, and if so what?
With the implementation of the *Medicare Access and CHIP Reauthorization Act*, the AAFP has called for the documentation guidelines to be eliminated for codes 99211-99215 and 99201-99205 for primary care physicians for all three domains: history, physical exam, and medical decision making. If CMS eliminates the documentation requirements for the history and physical exam domains only, then guidelines to support medical decision-making driven E/M documentation need to be in place first and broadly agreed to by the medical profession.

We appreciate the opportunity to provide these comments. Please contact Robert Bennett, Federal Regulatory Manager, at 202-232-9033 or rbennett@aafp.org with any questions or concerns.

Sincerely,

John Meigs, Jr., MD, FAAFP
Board Chair

CC: Ann Marshall, Hospital & Ambulatory Policy Group