

September 11, 2017

SUBMITTED ELECTRONICALLY VIA

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Seema Verma
Administrator
Centers for Medicare & Medicaid Services,
Department of Health and Human Services,
Attention: CMS-1676-P
Mail Stop C4-26-05
7500 Security Boulevard
Baltimore, Maryland 21244-1850

Re: Medicare Program; Revisions to Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for CY 2018; Medicare Shared Savings Program Requirements; and Medicare Diabetes Prevention Program; CMS 1676-P

Dear Administrator Verma:

The undersigned are pleased to submit comments in response to proposed revisions to the Medicare Physician Fee Schedule (MPFS) for CY 2018. We are a group of diverse specialty societies, organized in 2010, whose members provide “cognitive” services to our patients. Our comments are limited to Section II. I, the solicitation for comments and input on ways to reform the documentation guidelines for Evaluation & Management (E/M) services.

Our members have been greatly burdened by the E/M documentation guidelines since they were established in 1995, and believe they no longer reflect the care that is actually being provided by our members. We applaud CMS for recognizing how burdensome they are and its willingness to consider substantial revisions that will reduce burden, improve accuracy, reduce redundant documentation that hinders care and, will allow physicians to spend more time with their patients and improve care for Medicare beneficiaries. Our members have also been subject to audits by various Medicare contractors (e.g., MACs, RACs, ZPICs, SMRCs). The results of these audits are widely variable; there appears to be significant inconsistency in those reviews with many of these audits inappropriately determining that the wrong level of E/M was billed, resulting in significant time and resources being spent unnecessarily by physicians and CMS on the administrative appeals process.

We agree with CMS that reforming the E/M documentation guidelines is likely to require at least two years and likely longer. The vital components of E/M services have evolved, medical practice has changed and the E/M documentation guidelines are out of date and place unnecessary burdens on physicians.

Request for Immediate Relief. We agree with CMS that medical decision-making (MDM) and time are the two most important factors in determining the level of service. That is why the undersigned are requesting CMS to grant our members immediate relief from burdensome time-consuming audits while this process unfolds. Specifically, we request that all Medicare auditors of E/M services immediately

stop reviewing medical record documentation of any history and/or any physical examination. In determining the level of service, the only documentation reviewed should be the level of MDM or, when counseling or coordination of care comprises more than 50% of the encounter, time. If the auditor is uncertain as to the level of MDM, and, for time based coding, time is not documented, then, the general content (but specifically not the length of the documentation, the number of bullet points, or the number of systems) of the documented history and/or physical examination also could be reviewed to determine whether it supports the level of MDM for the service that was billed. This will immediately improve care because it will allow physicians to spend more time with their patients, and will help to unclutter the medical record because documentation will be consistent with what physicians actually need to document for care. We would be happy to work with CMS and the various contractors who perform audits, to implement this approach.

Long Term. In the longer term, with respect to the process for reforming the guidelines, we also agree that it is important for all stakeholders to come to consensus as to what those changes should be, before they are implemented. The goals of E/M guidelines reform should include: (1) improving care, (2) reduced burden, (3) alignment of the guidelines with the activities actually being performed by physicians before, during, and after an E/M service, and (4) allowance for objective, consistent, and reliable audits that do not result in disputes and lengthy burdensome administrative appeals. We also agree that the development of the electronic health record has changed the nature of documentation of the history and physical examination and made it unnecessary to audit those components to determine what service was furnished. We also agree that medical decision-making (MDM) and time are more important determinants of the level of service furnished but note that while the time of a visit is quantifiable and easy to document, the complexity of MDM is not quantitative or easy to document. For example, arriving at a diagnosis of influenza may be simple and easy, or it may be very complicated and require very complex decision making. Therefore, while we agree with CMS' goals, we caution that having predetermined notions of the endpoint of E/M guidelines reform may not be advisable and result in unintended consequences. For example, it is very important that audits of E/M services be consistent and reliable across reviewers and contractors, and we are concerned that if MDM is going to be the major (or only) determinant of the level of E/M furnished, consistent review of medical records may be difficult to achieve.

We also agree with CMS that these revisions, in and of themselves, should not result in the need to revalue these services. The E/M documentation guidelines were never related to valuation - they are only intended to facilitate medical review and that reforming the guidelines is necessary to make them consistent with current medical practice. Keeping this in mind, we seek assurance from CMS that any revisions to the guidelines independent of changes to the E/M codes and coding structure will not result in referral of any E/M services to the RUC for review and that CMS will not undertake an independent review of the valuations of these services.

First, we recommend that the initial focus of CMS should be on establishing a reform process that is iterative (e.g., goes through multiple drafts), is inclusive of all stakeholders, transparent, and allows for multiple opportunities to comment. Specifically, we recommend that CMS take specific steps to assure that the following stakeholders are included in the process to achieve consensus on E/M guidelines revisions:

- Organizations representing physicians and other health professionals who perform E/M services
 - Including physician members and staff who are on the organizations' coding (or other relevant) committee(s)
- Organizations representing practice groups (e.g., Medical Group Management Association, Association of American Medical Colleges)
- The CPT Editorial Panel
- Individual physicians and physician practices of all sizes that represent a cross-section of those who care for Medicare beneficiaries (e.g. by practice type, size, location, specialty, and use or non-use of an electronic health record)
- All appropriate CMS components, including physicians and analysts from the Center for Medicare and Program Integrity.
- Medicaid medical officers and policy makers from CMS and from individual states
- Medicare contractors
 - Representatives from all contractor types that perform audits of E/M services (e.g., contractor medical directors, nurse reviewers)
- Commercial payers
 - Representatives from multiple payer types (e.g., BCBS, United, Kaiser) who are individuals who perform audits of E/M services
- Manufacturers and developers of electronic health records
- Independent policy makers
- Coding experts who are experienced in, or consult on, E/M coding issues
- OIG
 - Individuals who investigate and prosecute cases where billing for E/M services is an issue

The undersigned are very concerned that representatives from all types of organizations who audit E/M services (including those who conduct the audits) and who investigate alleged improper billing of E/M services must be included in this process. Such inclusivity is needed to assure that auditors and investigators agree with and implement any revisions to the standards and criteria used to perform audits and conduct investigations based on the E/M guidelines as a result, and with a deep understanding, of the proposed process. The undersigned also believe that non-physician coding experts (e.g., certified coders) must be part of the process, as they are the individuals who educate on the guidelines and perform internal audits to assess compliance with the guidelines. Therefore, they may be in the best position to understand how the guidelines will be implemented, the challenges in educating on the guidelines, and whether compliance can be assessed reliably and consistently across reviewers from organizations with very different functions (e.g., Medicare auditors, commercial auditors, Federal investigators).

Second, we recommend that CMS assure the process is transparent and provides opportunities for all the above listed stakeholders to constructively participate and be heard. We recommend that CMS hold public meetings that allow each stakeholder type to be heard. For example, CMS could convene a series of public round tables with each round table focusing on a different stakeholder group. After that, CMS could conduct additional public meetings (e.g., round tables) to come to consensus on each issue.

Third, we recommend that the process address the following issues to assure that any revisions address the current problems with the guidelines while minimizing any unintended consequences:

- History of the guidelines and how they came to be in their current form
- Problems with each element of the guidelines (history, physical examination, MDM, time)
 - Burden
 - Representation of current physician practice
 - Advantages/disadvantages
 - Qualitative vs. quantitative
 - Reliable, reproducible, consistent review
- Advantages and disadvantages of removing each element from the guidelines
- Advantages and disadvantages in increasing the weight of existing elements or of adding new elements
- Advantages and disadvantages of using time as the sole criterion for determining the level of E/M service

At the end of this process, CMS should achieve consensus that the revisions work for all stakeholders, minimize burden to all stakeholders, represent activities currently being performed during E/M services, and will result in fair, consistent, and reliable audits and investigations.

In summary, the Coalition makes the following recommendations:

Request for Immediate Relief

- All Medicare auditors of E/M services should immediately stop reviewing medical record documentation of any history and/or any physical examination. In determining the level of service, the only documentation reviewed should be the level of MDM or, when counseling or coordination of care comprises more than 50% of the encounter, time. If the auditor is uncertain as to the level of MDM, and, for time based coding, time is not documented, then, the general content (but specifically not the length of the documentation, the number of bullet points, or the number of systems) of the documented history and/or physical examination also should be reviewed to determine whether it supports the level of the service that was billed.

Long-Term Reform of the E/M Guidelines

- The process should be transparent, inclusive, and should result in consensus among all stakeholders.
- The current valuation of all E/M services should be presumed correct, and the goal of reforming the E/M guidelines is to make them consistent with current medical practice.

We appreciate the ability to submit these comments, and we stand ready to work with CMS to achieve its goals and to improve the care furnished to Medicare beneficiaries. Please call Paul Rudolf at Arnold & Porter Kaye Scholer LLP at 202-942-6426 if you have any questions about these comments.

Signed:

- American Geriatrics Society
- AMDA – The Society for Post-Acute and Long-Term Care Medicine
- American Academy of Home Care Medicine
- American Academy of Hospice and Palliative Medicine
- American Academy of Neurology
- American College of Physicians
- American Gastroenterological Association
- American Psychiatric Association
- American Society of Addiction Medicine
- American Society for Blood and Marrow Transplantation
- American Thoracic Society