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Roberta Buell

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E&M Documentation Guidelines

by Roberta Buell, M.B.A.

Q: *As an oncologist, I'm confused about HCFA's plans to implement new E&M guidelines. What can oncologists expect? How can we prepare for these changes?*

A: Last summer, "new" evaluation and management (E&M) documentation guidelines were drafted by the American Medical Association (AMA) and the Health Care Financing Administration (HCFA) for implementation January 1, 1998. These guidelines were modifications of those released in 1994. Many physicians, especially oncologists, thought the revisions were convoluted, clinically irrelevant, and unintelligible. If you were one of those people who resented having to assimilate complex documentation guidelines, I'm happy to tell you that they have been indefinitely postponed.

Instead, officials from AMA and HCFA drafted a new framework for E&M documentation. The draft is a direct result of an April 27, 1998, meeting in Chicago to receive feedback on the 1997 guidelines. This draft is now being reviewed for implementation next year.

This draft outlines major changes to all three major components to E&M documentation—the history, physical exam, and (everyone's favorite) medical decision making. Look for a package of these possible changes this summer. Highlights of the proposed changes include:

History. Currently, documentation of higher level consults or visits (Levels 4 or 5) must have complete recording of three components of the history. Complete recording means: four components of the history of present illness (HPI); a review of ten organ systems (ROS); and the past, family, and social histories (PFSH). The revision states that a physician must have at least two of these completely documented.

This rule would benefit oncologists, whose chart audits have usually included good HPIs and PFSHs in initial consults. Yet in my experience rarely have I seen oncologists complete reviews of ten organ systems. Using 1994 or 1997 criteria, lack of a systems review would reduce a Level 5 consult to a Level 3 in an audit. In the proposed criteria, the consult without ten organ systems would still qualify for Level 5.

Physical. The 1997 criteria for both multisystem and single-organ systems exams is in the trash can. These exams might be changed to a menu of more than 175 elements organized by organ system and body area. The clinician could choose what elements in the menu are most relevant to the patient's condition and history. Code selection would depend on the number of elements selected. Just what that number is has not yet been determined.

Medical decision making. Within the proposed criteria there would be only three levels of decision making: low, moderate, and high. There are also three elements to decision making: the number of treatment options, the amount or complexity of data to review, and the level of risk of current decisions. Two of three must be documented for higher levels of coding. In the future, the highest level of documentation of these criteria may drive the code.

Medicare still requires that oncologists follow documentation guidelines. Take your choice between 1994 and 1997 criteria—but your practice must conform to one or the other.

Don't be too preoccupied with fraud. The prospect of paying a $10,000 fine for each E&M code incorrectly billed is admittedly a scary one. However, HCFA has repeatedly stated that these penalties will be levied only if a physician "had reason to know coding...will result in greater payments than appropriate." There also must be pattern of "deliberate ignorance." The billing of 99215 for every office visit would be an example of "reckless disregard" for coding and documentation parameters, i.e., deliberate ignorance!

Don't feel safe using 99213 for each office or clinic visit. Oncologists are likely losing money using 99213 for a visit they think may be routine and of low complexity, but is actually not. E&M criteria were written for primary care physicians whose patients are not as sick as patients with cancer. In addition, billing all codes to one level can trigger more than your share of prepayment audits.

I hope I didn't increase your confusion. By the end of summer, we will have more clarity on documentation for physicians' E&M services and also for nursing services using 99211. In the meantime, however, I'll do my best to answer your questions.

Roberta Buell, M.B.A., is president of Intake Initiatives, Inc./Documedics in San Francisco, Calif.

Have a coding question? You can direct your questions to Ms. Buell via e-mail at codemistress@documedics.com, or write to Ms. Buell c/o *Oncology Issues* at 11600 Nebel Street, Suite 201, Rockville MD 20852-2557. Fax: 301-770-1949.