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## August 2018: Proposed Rule Change to E&M Documentation

You read that correctly. After 21 years, CMS is proposing a significant change to how we, as doctors and other providers, are required to document in a medical record. Prior to 1995, there were no rules to follow when it came to billing a medical office visit. But in 1995, the first set of documentation guidelines was released to give direction about what was required for different levels of care that doctors provided. Then in 1997, they released a new set of guidelines that were tailored to the different types of providers...psychology document findings very differently than optometry/ophthalmology. Since that date, nothing has changed in regard to what is required to earn the different 99000 E&M codes. As frustrated as many doctors get when it comes to grading the different levels, the rules have been consistent for decades and we have been able to create templates to make sure we were doing it correctly. Although, based upon the thousands of charts I have reviewed, there is still A LOT of confusion.

It appears doctors, and CMS, have reached a boiling point with the old system. Now that EHRs are mainstream, the old system just doesn't seem to make much sense anymore. With the ease of looking back at prior exam findings, being able to pull items like the ROS forward, and simply the evolving "living document" that an EHR has become, it doesn't make sense to grade it the way we did when we used pen and paper. The exam findings and documentation are more fluid now than ever. With this change in how we document and review patient's findings, we have been forced to put a round peg into a square hole with our old documentation guidelines. The proposed changes appear to bring the documentation and coding requirements into the modern age. Below is direct wording from the proposal's fact sheet.

### ***Streamlining Evaluation and Management (E/M) Payment and Reducing Clinician Burden***

*CMS is proposing a number of coding and payment changes to reduce administrative burden and improve payment accuracy for E/M visits. We propose:*

- *to allow practitioners to choose to document office/outpatient E/M visits using medical decision-making or time instead of applying the current 1995 or 1997 E/M documentation guidelines, or alternatively practitioners could continue using the current framework;*
- *to expand current options by allowing practitioners to use time as the governing factor in selecting visit level and documenting the E/M visit, regardless of whether counseling or care coordination dominate the visit;*
- *to expand current options regarding the documentation of history and exam, to allow practitioners to focus their documentation on what has changed since the last visit or on pertinent items that have not changed, rather than re-documenting information, provided they review and update the previous information; and*
- *to allow practitioners to simply review and verify certain information in the medical record that is entered by ancillary staff or the beneficiary, rather than re-entering it.*

*To improve payment accuracy and simplify documentation, we propose new, single blended payment rates for new and established patients for office/outpatient E/M level 2 through 5 visits and a series of add-on codes to reflect resources involved in furnishing primary care and non-procedural specialty generally recognized services. As a corollary to this proposal, we propose to apply a minimum documentation standard where Medicare would require information to support a level 2 CPT visit code for history, exam and/or medical decision-making in cases where practitioners choose to use the current framework, or, as proposed, medical decision-making to document E/M level 2 through 5 visits.*

Within this proposal, there is also discussion of expanding access to telemedicine by integrating the care and billing of these services into traditional in-office care. This would include *Brief Communication Technology-based Services* and *Remote Evaluation of Recorded Video and/or Images Submitted by Patient*. The Brief visit is intended to be used to decide if an office visit is needed. The latter service would allow doctors to be reimbursed for reviewing photos or videos submitted by the patient. I can see this being useful for situations like a subconjunctival hemorrhage. And I know we will all become more comfortable with other services as the technology improves. None of these changes will be happening tomorrow, but the wind is changing. And it appears to be for the better.