Implementing CMS 2019 E/M Documentation Guidelines


As part of its “Patients Over Paperwork” initiative, the Centers for Medicare & Medicaid Services has sought input from physicians and other stakeholders on how to reduce the documentation burden associated with E/M services. With the new guidelines, CMS is simplifying documentation in two ways:

- When relevant information is already contained in the medical record, practitioners may choose to focus their documentation on what has changed since the last visit, or on pertinent items that have not changed, and need not re-record the defined list of required elements if there is evidence that the practitioner reviewed the previous information and updated it as needed. Practitioners should still review prior data, update as necessary, and indicate in the medical record that they have done so.
- Practitioners need not re-enter in the medical record information on the patient’s chief complaint and history that has already been entered by ancillary staff or the beneficiary. The practitioner may simply indicate in the medical record that he or she reviewed and verified this information.

**EHR Documentation and Template Functionality**

It seems obvious that new guidelines requiring less documentation would be easy to implement. However, the documentation structure in current electronic health records (EHRs) was developed based on 1995 and 1997 E/M guidelines. Specifically, EHR templates are commonly designed to anticipate and populate the history and exam normal findings, as related to elements that are nearly always addressed. The physician then revises the findings to reflect any presenting abnormality. Some EHRs allow the physician to select, for example, the cardiovascular exam and work through a stream-of-logic for issues identified.

Currently, most systems have moved away from date stamping every entry in the record as a visible documentation element on the legal record. As such, it may not be clear whether the physician cut and pasted the exam into the record from the prior visit or if he or she generated the documentation on that date of service. An additional statement may be needed to clarify this point.
CMS’ new guidelines state that the provider can reference previous information and document an update from the last visit. There are at least two ways a provider can accomplish this:

- Use a free-form text field to reference relevant previous-visit documentation by date. Example: “I have reviewed the history and exam documented in the previous visit note dated 1/5/2019, which are incorporated into today’s note except for changes as documented below.”
- Document the history and exam update in free-form text fields, unless documentation elements can be populated without normal findings automatically populating (e.g., review of systems or exam elements - constitutional, eyes, etc).

Under the new rule, a provider must reference a prior note that either:

- Was documented with the required elements for a given level of service.
- Further references a note containing required elements.
- Lists multiple visit dates which are relevant and account for the required elements.

In other words, the provider’s documented update and reference to prior history or exam must meet, in total, the history and exam elements required for the code level billed. For example, a provider could document an initial visit according to the 1995 or 1997 guidelines, and, then, the subsequent note could reference the history or exam previously documented and provide an update to meet a given level of service. EHR templates will need to allow for full documentation according to the 1995 or 1997 guidelines, as well as the ability to both reference the previous note and document an update.

*Note that CMS has not provided expectations for the way in which its new guidelines will be audited. Therefore, monitor CMS and your local Medicare Administrative Contractor (MAC) for direction.*

**Considerations for Implementation and Future Rule-Making**

CMS’ new documentation guidelines apply only to the office/outpatient E/M services furnished for traditional Medicare beneficiaries; CMS has no authority to dictate what documentation other payers will require. Unless and until a payer announces the adoption of the new documentation guidelines, physicians will still need to adhere to current guidelines for services billed to other payers. Thus, providers wishing to rely on CMS’ approach for less documentation will need to create Medicare documentation templates separate from other payer templates.

CMS should be applauded for pushing this issue, since the medical community could not agree on changes. However, the way the industry handles the situation matters. CMS intends to reduce provider burden, but anything that requires more decisions for a provider ultimately equals more burden, not less. Until and unless a solution—one that eases burden—is agreed to by all payers, providers are not likely to adopt it.

Now that CMS has prioritized the issue but delayed reimbursement changes to 2021, perhaps the industry will come together on an implementation strategy and will design E/M guidelines and/or codes that address these changes. In the Final Rule, CMS calls for the CPT Advisory Panel to make E/M code changes in response to these industry complaints. As such, the Advisory Panel now has a committee in place and is moving forward on these changes. In the meantime, it will be important for CMS to provide clear direction on what documentation is required and what will be audited.

The downside of CMS only calling on the CPT Advisory Panel to make changes is that solutions beyond
CPT codes may not be considered. For example, what if risk-adjusted reimbursement based on a hierarchical condition category (HCC) (i.e., reimbursement driven by the complexity of diagnoses) is the answer? Additionally, the industry must consider future data capture and management technologies, as well as solutions that reduce documentation, coding, and billing process burden while still proving meaningful and useful for population management and improved outcomes.

**CMS E/M Documentation Guidelines Implementation Checklist**

As noted, there are numerous considerations that must go into determining whether the reduced documentation guidelines are a fit for your organization. The following checklist delineates a number of items to be considered, understanding that each requires additional analysis.

- Determine if CMS’ new guidelines are a reasonable option for your providers.
- Create templates that allow for references with entry points for the date of the previous visit as well as updates.
- Determine if your EHR will allow providers to toggle between CMS’ reduced documentation and other guidelines.
- Create policies and procedures representing your facility’s interpretation of the guidelines.
- Train providers and perform periodic documentation reviews to monitor compliance.
- Watch for clarifications for these guidelines and auditing methodology from CMS and your MAC.

PYA routinely assists providers with translating the regulatory guidelines into everyday operations through a deep understanding of both. We are available to assist your organization as it evaluates the pros, cons, opportunities, and potential pitfalls of implementing specific changes in response to new CMS guidance. For more information, or if you would like assistance in any matter involving compliance, valuation, or strategy and integration, contact one of our PYA executives below at (800) 270-9629.

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