Editor’s Note

The E&M Guidelines Controversy

The following two editorials discuss the recently proposed evaluation and management (E&M) guidelines. Sentiments such as those expressed in these editorials have finally been heard loud and clear. It was announced at a recent American Medical Association “fly-in” meeting held in Chicago that the proposed date of July 1, 1998 for implementing the E&M documentation guidelines has been postponed indefinitely. The guidelines will be reviewed thoroughly to address criticisms such as those expressed below. This editor is quite pleased by this development.

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CPT Coding and Medicare Reimbursement

From Beans to Bullets

In 1992, I was appointed to the American Medical Association/Current Procedural Terminology (AMA/CPT) Advisory Committee as the representative of the American College of Chest Physicians. Two years before this appointment, I had received a letter from the AMA/CPT staff describing the process that the AMA was exploring with the Health Care Financing Administration (HCFA), whereby the components of the patient history and physical examination would be used to determine the level of service for Medicare reimbursement for evaluation and management (E&M) services. I immediately wrote back to the AMA, as an internal medicine residency program director and a lifetime medical educator, indicating that the components of the medical history, such as family and social history and review of systems, had little or no bearing on the complexity of the service being provided, be it an initial assessment, a follow-up visit, or a consultation. The more acutely ill the patient may be, particularly during a hospital admission or consultation, the less likely the attending physician is to perform a 10-system review of systems or a detailed social history. The intensity and complexity of the services are by no means less because of this omission, and in some cases time spent obtaining this information for the record could impact adversely on patient care. In fact, the most appropriate history and physical examination in complex acute illnesses is often problem focused, while the level of service provided is the most comprehensive. Simply stated, the elements of the history and physical examination are not indicative of the complexity of the service or the level of service being provided. I did subsequently receive a response from the AMA expressing some minor concern that I did not agree with this approach but demonstrating no real understanding of my concerns (unfortunately, I failed to save this letter because it would be most enlightening to reproduce today).

Even though this approach to assessment of the level of medical service being provided made little sense to physicians who evaluate and manage patients, it had the great advantage of allowing Medicare auditors with very little medical knowledge to review patient records and count the “beans” necessary to justify or deny the level of service being billed. Some might say that this is the price we pay for insisting on a fee-for-service national health care system for Medicare recipients, as opposed to a capitation system where expenditures could be precisely determined well in advance. Nevertheless, this is the reimbursement system that was supported by the AMA and the one that haunts all physicians who provide E&M services today. Fortunately, for those physicians who perform procedures, there is no requirement to document level of service, only personal presence during the critical portion of the procedure.

Beginning in October of 1997, a new system for documentation of the level of service commensurate with the contents of the physical examination was introduced. The AMA, in conjunction with HCFA, has developed single-system examinations for most of the major organ systems and a general multi-