

From the Archives:

The AMA's Documentation Guidelines: Physicians' Reactions

[The AMA organized a "fly-in" to Chicago on Apr 27, 1998, because of physician outrage over the AMA's proposed 1997 evaluation and management (E&M) documentation guidelines, which bore an AMA copyright notice on every page. Dr. Jane Orient tape recorded the following session, and edited a transcript. The full edited transcript from which the following remarks were excerpted is available at www.aapsonline.org/medicare/flyin.txt.]

[Dr. Randolph Smoak, vice chairman of the AMA Board, introduced the comment session, asking each participant to limit remarks to two minutes. Green, yellow, and red lights were placed on the podium. The time for comments was limited to one hour, so a maximum of 15 people could fit in if people on the dais and at the microphone cooperated with the time limits. He stated that the goal is a Federation-wide solution. "Let's not focus on points that we differ on but on points that unite us in this real world."]

Dr. George Hare, Medical Society of New Jersey: New Jersey wishes to make this thing work, and the physicians there will do whatever is necessary to have a user-friendly document. . . .

Somewhere the physician must be recognized for what he or she does. We know that HCFA [the Health Care Financing Administration] wants to make sure that we are doing it properly. . . .

Documentation must not be rigid; it must allow flexibility for the specialist who does not do what I do as a geriatric physician. . . . I don't want surgeons to clutter up my records because they are trying to do other areas that they have not been asked to do. They get in my way, and I must ask them to stay out of my area of expertise. . . .

I ask you to give us a user-friendly document that we can work with and support what is necessary. We have no problem with weeding out physicians who abuse the system. If you get them, and they are abusing it, and you know they are abusing it, take them out of medicine; we will support you 100%.

Dr. Lee McCormick, president, Pennsylvania Medical Society: I believe that somebody needs to say that most physicians are in fact providing the services for which they bill. Now they may not be documenting, but I don't think HCFA is being cheated very much. . . . As a matter of fact, I think that more physicians are down-coding because they have concerns that their documentation may not in fact meet the level of service they provide. I think physicians being the bright folks that most of us are will learn to document better, and I think that the payments to physicians will then go up because they will in fact be documenting what services they provide. Now my fear is that we can't win because then I think that our payments will be ratcheted down because we are billing too much. . . .

I appreciate all of the statements about the intent to go after only those who would willfully and intentionally defraud the system. Now we all know in the history of this country, there has never been a government agency or a government official who

abused power. (Laughter, applause) We accept that as a given. If such a rogue were to suddenly appear and start to pursue physicians who were making mistakes, what is our recourse? What can we do, can we go to somebody in HCFA, or the OIG, and what will our AMA leaders do if that should happen?

Dr. Melvyn Sterling, California Medical Association: Now look around this room. There are what 300 of us here, and we are here because of a crisis in medicine and this is not a crisis of a new plague; it is not a crisis of antibiotic resistance; it's a crisis [made by] our government. In this room, there is an endocrinologist who quit medicine because of these guidelines. In this room, there is a general internist who no longer takes any new Medicare patients. In this room are representatives of medical associations in large cities where physicians no longer accept any new Medicare patients. What is wrong?

Physicians are demoralized; physicians are frightened; physicians don't feel that they are being treated fairly; physicians feel that they have to stand up and say that they are not crooks. What is wrong?

We know that there are people who submit inappropriate claims, and we know that the government has the ability to find those physicians and other people who bill Medicare. . . . [The E&M guidelines] distort the purpose of our clinical record, the tool that we use to take care of our patients, so that these things can be prevented instead of rooted out and dealt with when they occur. . . . but that can't be done.

Now the proposed documentation guidelines that brought us all here with their horrendous number of bullets, that was the camel sticking its butt into the tent and we said, "This stinks." And everybody heard us and you know what's happened, that camel turned around and now we see fewer bullets; we see the nose of the camel sticking its head under the tent flap. Ladies and gentlemen, we don't want that camel in our tent.

Dr. Morton Field, American Association of Clinical Endocrinologists: [Just before I left, I consulted on a complicated patient. After reviewing all the data and spending more than an hour with the patient,] I wrote in my report, "Patient is stable." This is perfectly adequate for the general internist for whom I am doing the consulting work. . . . Now I object to someone who wants me to get up there and write like a third-year medical student. . . . (Applause)

Dr. Jacinto del Mazo, Medical Association of Georgia: I came here 30 years ago. When I came here, I was amazed at the degree of respect, appreciation, even admiration that our patients had [for their doctors]. In these last 30 years, I kept seeing the profession going from an admired profession to a special interest, to being criminalized. This has happened during the watch of the present leadership and the previous leadership of the AMA. I have been talking at length and organizing a group of physicians.

At this time, not a single one has been satisfied with what the AMA has been doing on this issue. We come here to express opinions, and we have one hour to talk, but the rest of the time is for some kind of way to indoctrinate us.... [I talked to a physician recently who said he hadn't been paying dues to the AMA for a number of years. I asked him why.] He said, "When I...get somebody to cut the grass, [and over and over he doesn't cut the grass], eventually I don't pay him." I say you are looking at the situation wrong. You need to get the grass cut.... You need to have someone looking after your interests, which I'm not sure the AMA is doing at the present time. The implication that there are \$20 billion dollars of improper payment is obscene. Basically, since the physicians make 19% of the payments, the implication that 10% of them have made an error [means that] physicians will have to work for free and pay for the privilege of working. Something is wrong; the measurements are wrong....

Dr. Nancy Dickey, AMA president-elect: [The question is whether we] prefer to have HCFA contracting with someone that is a corporate entity that either has no physician input or has only its corporate physician's input. We heard you in December; we had worked hard and as soon as we get done with this open comment, some members of the CPT panel, Dr. Henley in particular, are going to present the work that has gone into trying to take the comments that have come since December from physicians in trying to correct, improve, make better the documentation process.... We are all here today listening, and saying here are the steps we have taken, and [asking] are they the right direction or do you want to do something else, because the AMA [believes] physicians...would rather have a process in which you can gather like this, and someone will listen to you.

Now, is it a perfect process? Certainly not. Did we make errors in the documentation...guidelines that came forward? Obviously so. But having an organization that speaks for physicians, and that organization choosing in this instance to [hear your voice rather] than to have black boxes as we had in the past, gives you the opportunity to come together and say, "Hey, it's not working; let's try to change it." I would say to those people who don't pay dues that the delay that we got until July 1 came from those of you who pay your dues,... but the non-dues-payers are going to benefit from it just as much as those of you who pay dues. We ought to be very frustrated by the small number who are carrying the load.

Dr. T. Reginald Harris, Current Procedural Terminology (CPT) editorial panel: This meeting is a culmination of a lot of work by your AMA leadership.... The letter that you received from HCFA and Nancy-Ann Min DeParle today via Dr. Berenson [announcing an indefinite delay in implementation of the 1997 E&M documentation guidelines] didn't just happen; it happened because a lot of work and a lot of our time has been spent communicating with HCFA and explaining the problem that you are enunciating and our frustration with what is happening. Our staff has been in constant contact; we are working hard on your behalf, and meetings like this are what come out of the AMA's efforts.

Dr. Mitchell Miller, president, Virginia Academy of Family Physicians: About eight days ago we sponsored a meeting in our state to review these guidelines and also invited the representative of our state carrier [including the president in charge of the fraud and abuse division] to discuss what we are discussing today and to try to reassure...our members about...what...they might

expect from that office. A particular issue came up about...the documentation of home-care providers and durable medical equipment providers, and the fact that we spend hours of our week...signing this documentation..., really receiving no reimbursement for doing so. Now the problem with that is [that] most of the time we have no idea what is really going on out there; we are...taking a leap of faith in the fact that the services are being provided that are being sent over to us for a signature. We specifically asked this person...what exactly is our liability.... We received no reassurance at all; in fact, [the official] said you guys better not sign that; you better read every page of that very carefully. [But] we have no time for that.... We were essentially told by the state carrier's representative on fraud and abuse that we [have a high level of] liability for signing things that we really don't have a whole lot of control over.... So while you are trying to be very reassuring to us today that just being basically good physicians and doing what we are supposed to be doing we shouldn't have to worry about this higher level of pursuit by the OIG,... we are not getting that reassurance on the state level.... [H]ow can we continue to persuade physicians of our state and across the nation that in fact we are not sitting in jeopardy on a regular basis from these kinds of pursuits?

Mr. Joseph Vengrin, deputy inspector general for investigations, Department of Health and Human Services: I am not going to be able to give that answer today. I am aware of this issue and will look into it much more than I have up until now. It is of concern....

Dr. Robert Berenson, Center for Health Plans and Providers, HCFA: I believe that if you make the certification, it's a problem.... There are many legal ramifications, and I think that it needs to be looked into further.

Dr. Stephen Babic, Florida Medical Association: I think what you hear here and we have heard for the past weeks and months is that this system is too complex. My friend who is an M.D. and M.B.A. could not figure out the proper coding for ophthalmology. That is a big problem. We don't see how in the next 6 months that you are going to correct this problem.... I am an intelligent human being, I have been through medical school, graduate school, internship, residency, and you have made it difficult for me to try to practice medicine. That is one concern.

The second concern is why are we doing this to begin with? Does it improve the care of my patient? The general perception is... that it is not going to improve the care of my patients. It is only to try to get us to down-code for the government to save money....

The third thing... is that in Florida we have been told that 38% of the physicians' offices will be audited. The penalties will range anywhere from \$10,000 to \$500,000; the average will be \$80,000. When you come in and you assess a penalty to us, what you have done in the past is [to send] us a letter saying, "You have an \$80,000 debt to the government, you have 30 days to pay it, and if you don't pay it we are turning off your Medicare computer."

Mr. Vengrin: Sir, I am not now aware of any OIG effort centering in on physicians at all. If you can give me more specificity, I will certainly bring it back to the chief.

Dr. Joseph Bailey, Medical Association of Georgia: The language of medicine emanates in medical school and residency and fellowship training programs, not from...programs to...bill

for services.... [In confusing these two things], we are very much in danger of destroying the reality of medicine, which involves the translation of patients' problems into workable solutions, not into a mechanism that will ultimately satisfy the Federal government or other third-party payers.... If you sit down and try to figure out how to bill and comply with the current government [regulation] involved in the control of our profession you are going to spend the rest of your life working on that and not furthering your education or improving your ability to take care of the...patient....

Dr. George Sample, Society of Critical Care Medicine: Those of us who practice critical care medicine use 99291 as our major code.... In 1994 it represented the 22nd highest payment benefit nationally, and it has caught the attention of a lot of people.... [T]hose who use that code are highest on the OIG's hit list, second to drug traffickers. The work plan for 1998 for OIG includes investigation of those of us who use 99291.... I have about six examples in which a quarter of a million dollars is the usual penalty for upcoding to the tune of \$8,000 or \$10,000. So in fact although it is not a criminal penalty, this financial penalty will essentially put them out of business....

Mr. Vengrin: I really can't comment on some of the open investigations; I don't know whether it's a part of our office or part of DOJ [the Department of Justice]; I certainly can't speak to DOJ but I echo your comments.... [I]n terms of these investigations that are going to be around, I would like to make it go away for you, but I can't. But clearly in terms of legal liability and patient care, we have got to do something and work together on this documentation issue.

Dr. Smoak: We have heard this type of thing in the past, and it really always scares the daylights out of us when we hear the numbers that Dr. Sample commented on. We never know the vignettes in which those occurred. Is it possible that you can supply some accurate information that wouldn't be prohibited in some way to Mr. Vengrin so that in some way we could get an answer to it? I am sure it would be very satisfying to many of us in this room if we had some idea of the validity of that because you know so many times things get started and there is nothing to it; it is totally misconstrued....

Dr. Thomas Reardon, AMA chair: We hear these circumstances, but we need some factual information.

Dr. Jane Orient, vice-president, Pima County Medical Society (Tucson, Ariz.), and executive director of AAPS: The details of our concerns we passed out in a white envelope. If you want one and didn't get one yet, I would be delighted to give you one. I want to just get to the basic premise. We all seem to be accepting the assumption that because [10% of the claims representing 19% of Medicare spending] aren't considered to be justified, we are going to impose a very expensive, onerous system of documentation on all physicians in the country, which could be used as a tool to prosecute anyone because we believe 100% compliance is essentially impossible.

Now the American Bar Association has an ethical code for lawyers about their documentation, and it says you will protect the confidentiality of your client. Instead of that, we are going to have medical documentation that makes us into scribes for the government and the insurance industry. In order to collect third-

party payments we have to put all of this detail in the record that will be turned over to a third party, to the patient's detriment.

Now some of our members have said to us [that] we have the distinction of belonging to the generation that gave away medicine without a fight. I submit that it's worse than that. We are part of the generation that is forging its own chains and handing the keys to HCFA or to the federal government. All of their good intentions that you will be prosecuted only for doing egregious things really don't have the force of law. They are irrelevant. They may sound good, but they are not going to protect doctors who fall into the pit. They are certainly not going to protect the patients.

I think we are selling out our patients' confidentiality, and we are selling out our own integrity. The proper position of the AMA on this should be simply to say that the practice of medicine and the medical record cannot be reduced to a series of check boxes enforceable by law. If the AMA is not willing to take that position, then maybe physicians should reject the AMA as their representative. I do have a question for you: Does the AMA have a contract with the Federal government, and when will it release the details of this contract to its membership?

Dr. Reardon: Thank you. Let me give you a little history on CPT. CPT has been in effect for 32 years, since 1966. In 1983, yes, the AMA [signed] a contract with HCFA to provide a coding system, which would be used in Medicare and Medicaid. We receive no money for that contract. Any money that we receive from the CPT activities are...royalties which we get from selling the CPT book.... We simply have a contract which is a physician-driven CPT organization so physicians have input into the coding system, and we have a contract to supply that to the government for their use....

Dr. Smoak: And I might add that there are other organizations with a royalty arrangement [that] purchase CPT material and sell it themselves in addition to the AMA; so it's not AMA alone. And now Mr. Vengrin has to leave right now and do you want to comment on that before you do, and then we want to thank you.

Mr. Vengrin: I believe that the documentation that the Federal government is attempting to get here is no different than that [which] is required for other insurance claims and also that which many of you have been doing [already]. I think that the statistics speak for themselves: 90% of these billings are okay. I think last year 86% were okay. This is the second year that we have done this. Documentation problems that surfaced out of these reviews are not new. The carriers have many more examples so I don't think we are dealing with a huge problem; I think we are dealing with a small group that needs the education that we talked about. I don't believe it's onerous, and I think we should continue.

Dr. Glenn Littenberg, American Society of Internal Medicine: I have to have a huge skepticism about the intention of the government; I am well aware of the case from the DOJ in which an indictment was handed down criminally to a physician through the Champus program based totally on a computer analysis of the CPT codes this physician used. The typical times were added up, and they exceeded the time the physician appeared to be spending in the clinic.... I actually wound up looking at some of the documentation and thought this physician did an outstanding job compared to what I generally see in practice. Not only this, but the guidelines that were being applied

in the case were being applied retroactively. There were cases that were being provided by the physician before the first set of guidelines ever got released.

Dr. Reardon: The debate on time or content came in 1990 with the implementation of the RBRVS [Resource-Based Relative Value Scale], and the Physician Payment Review Commission came forward with E&M codes based on time. Organized medicine led by CPT and the AMA said we don't think that is appropriate. We think that physicians should be paid for the work and the expertise and what goes into providing care for a patient, and... what came out is that the codes are based on content of work, not time, and so that's a debate that occurred 8 or 9 years ago.

[At the end of one hour, **Dr. Douglas Henley**, a member of the executive committee of the CPT Editorial Committee, gave a presentation that he said would "test your labyrinthine system very well." He discussed the role of the AMA in developing the E&M codes; such issues as the 10-day global and the 90-day global; the question of collapsing from five levels to three or four; the three-out-of-three rule for new patients and the two-out-of-three rule for established patients; artificial criteria such as location; the question of 150 versus 250 examination elements; the current 1,6,12,18 rule, versus a possible 1,5,10,15 rule or 1,4,8,12 rule. He thought the earliest implementation date for a new system might be July 1, 1999.]

Dr. Smoak thanked Dr. Henley for "assuring us a way out of this current mess that we seem to be in," and opened the floor for an additional 30 minutes of questions.

Dr. Walter Roberts, chairman, South Carolina AMA Delegation: I chaired the reference committee in Dallas that structured the current AMA policy regarding fraud and abuse, I mean the E&M Guidelines, I should say fraud and abuse as well because I think that stems from [the guidelines]. Since that time we have kind of been carrying this burden rather heavily on my shoulders. In Dallas I heard a lot of flagellation of HCFA by everyone present. After I left Dallas, I heard a lot of flagellation [of the AMA] and specialty societies, who said we weren't working effectively with HCFA. This morning I hear some what I think are very untimely and really vitriolic attacks upon the AMA for having performed poorly on this job, something which I do not think is fair... I for the first time want to speak on an encouraging note about what has happened here today already and what shows promise of encouraging things to happen in the future. I believe that the AMA is working with HCFA now and is genuinely trying to do these things properly....

Dr. Troy Tippett, American Association of Neurological Surgeons: We do remain concerned about the proposed system in which medical students can always do the level five examination and yet not know what they have when they finish doing the exam. We really think the crux of the issue is that there is no code for the art of medicine.

Dr. Jack Beller, Oklahoma State Medical Association: I am a practicing orthopedic surgeon. The members of the Oklahoma State Medical Association recognize the need for the accuracy, reliability, and completeness of a patient's medical record,...but we also recognize the unreasonableness of the threat of the charge

of fraud, imposition of fines, or imposition of other penalties or felonies based on a difference of opinion in the interpretation of these guidelines. We also understand that the medical record is a confidential instrument used to record a patient's care and his response to care. It was never designed for, nor intended to be used for a justification for payment.... The Oklahoma State Medical Association [unanimously passed a resolution stating that the proposed AMA E&M guidelines] are intrusive into [the] practice of medicine and detract from...quality care.... [W]ith this level of complexity, education is still very difficult or next to impossible.

Dr. Blair Filler, American Academy of Orthopaedic Surgeons: The problem...is the hammer, and the hammer is the Kassebaum-Kennedy Bill of 1996. It specifically states that you must show a pattern of behavior of either fraud and abuse or upcoding or miscoding [and you knew or should have known about the miscoding]. And there's a specific phrase in there that states that no intent to defraud is required for you to be looked into. We've been reassured this morning that they're not going to follow this rule. Where is that documented right now as far as HCFA is concerned and the inspector general is concerned?

...What does a "pattern" mean? Does that mean three miscodes or 20 miscodes...? [Is it fraud to not sign the record, or to put initials down, or to have a signature that is not legible to somebody?]

Dr. Leonard Weiss, Medical Society of the State of New York: I am also an orthopedic surgeon.... [It] surprises me that the people who devised this system didn't realize that it was totally unworkable before we got to this point. (Applause) We got from the American Academy of Orthopaedic Surgeons a five-page document on how to conduct a physical examination, history, and decision-making. I think that I am reasonably bright, and I was unable to comprehend it, and I realized it would take me longer to use their templates than it would to examine the patient....

Dr. Stephen Levinson, Connecticut State Medical Society: [R]egarding the so-called hammer,... our state medical society...advises us that any review of E&M coding goes through a section which is now called fraud and abuse.

Dr. Roger Williams, Montana Medical Association, American Society of Internal Medicine (ASIM), and American Academy of Neurology: I want to emphasize that the devil in all of this is the graduated codes on which reimbursement is based. I don't know whom we are kidding. We have already agreed that a physician's intelligence, training, and experience count for nothing in the Medicare system. The actual cost of providing the services counts for nothing in the Medicare system. The time involved in providing the service is minimized in the Medicare system.... The E&M Documentation Guidelines...have provided the government with a way of defining what they call inappropriate reimbursement, which is interpreted by the press and the politicians to be waste, fraud and abuse. Now we are going in a vicious circle in which we are all going to be ruining ourselves in the end....

Dr. Smoak: Thank you very much. Our time has expired. For those of you who remain at microphones I regret that we have got to move on. I would invite you to submit your written comments....