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Evaluation and management guidelines

Last year the Health Care Financing Administration issued new rules indicating how doctors must document the services for which they are billing Medicare. The guidelines define four levels of service: problem focused; expanded problem focused; detailed; and comprehensive. For each level there are detailed instructions on how to document the chief complaint, present illness, review of systems, and past, family, or social history. Each history of the present illness is defined as a chronological description which may include one or more of the following elements: location, quality, severity, timing, context, modifying factors, and associated symptoms and signs. The lowest level requires three elements, but for the higher levels at least four are needed.

The review of systems, "patients' positive and negative responses to questions," and the physical examination likewise increase from one system for the lowest level to at least 10 for the most comprehensive level. Details are also given on how many questions doctors must ask when taking the family and social history, depending on the level of service rendered.

To illustrate the reaction to these rules I could do no better than quote from an article in the *Wall Street Journal* by a Dr Robinson, who practices internal medicine in Washington DC:

"To justify a 25 minute visit with a Medicare patient, a physician will have to generate a written record including try to follow this chief complaint, an extended history of the present illness (four or more elements, or the status of at least three chronic or inactive conditions), a review of systems (an inventory of two to nine bodily systems); pertinent past medical, family and social history: plus either a detailed examination (including at least six organ systems or body areas with at least two elements each or at least 12 elements in two or more organ systems or body areas), as well as two out of three of either multiple diagnoses or management options, a moderate amount or complexity of data to be reviewed, along with the risk of complications or morbidity or mortality."

Dr Robinson goes on to explain that failure to document accurately could subject the "miscreant" physician to fines of up to $10 000 an incident; that a disproportionate amount of time would be consumed by pedantic record keeping; and that since a doctor can do only so much in 15 to 30 minutes all this unnecessary documentation takes away from the real business of making a diagnosis, formulating a treatment plan, writing prescriptions, explaining the problem to the patients, and possibly even comforting and consoling them.

The guidelines, originally set up jointly with experts from the American Medical Association, unleashed a storm of protest by doctors from coast to coast. Several generalist and specialist medical associations declared they were unworkable, too complex (48 pages), and fatally flawed. In the face of continuing protests their implementation was delayed several times and then indefinitely. It was also suggested, to quote Dr Robinson again, that if such guidelines are "good medicine for doctors, perhaps every government official and employee should be subject to similar work-substantiation requirements."