WHEREAS, The American Medical Association has advocated strongly for fair rates of pay for physicians regarding services rendered; and

WHEREAS, The CPT documentation coding changes for 2021 regarding office-based evaluation and management (E&M) services has had success in limiting our documentation and has placed a better focus on the value of the actual work physicians perform; and

WHEREAS, The current reimbursement system has placed a value on performing an E&M service regarding one or two problems that are new or chronic at each patient encounter; and

WHEREAS, Patients will frequently have more requests within a given visit than is currently designed to account for and it is recognized that being able to address more than one to two problems in a visit represents good patient care, good customer service, good continuity of care, and good medical care; and

WHEREAS, Proceduralists are currently allowed and encouraged to account for each individually recognized service that is performed for a patient at each encounter and this has been accepted by the whole of the AMA, and

WHEREAS, Those physicians who attempt to address more than one to two problems during a patient encounter as a result of a patient request or need, either by addressing those additional problems at that visit or by attempting to delay a subset of the additional problems to a future visit, are at risk of either delivering patient care at a value that is less than what is currently designed for by the AMA or is at risk of a patient gaining a perception that the physician has delivered a poor customer service experience for that patient at that encounter; and

WHEREAS, The perception of an excellent customer service experience has become ever more important with increasingly utilized star ratings as promulgated by common internet search companies and patient-centric medical rating services, and that the value of these star ratings strongly reflects upon the success of a medical practice; and

WHEREAS, being encouraged by patients, health plans, IPAs, and Medicare to perform more services in a visit than is currently designed and accounted for has the effect of decreasing the perceived value of these additional services within the eyes of the patient and below the value as designed by the AMA; and
WHEREAS, Office-based physicians who are exposed to such requests from patients and are able and wish to perform such additional services currently are continually placed in a position of not being fairly reimbursed for their services which in turn results in medical practices that 1) are not being able to offer a competitive rate pay to their staff; 2) are strongly encouraged by patients, health plans, IPAs, and Medicare to deliver their services at a lower than intended rate of remuneration; 3) are not able to present and utilize adequate resources for patients for the sake of quality patient care; 4) continually place their own wellbeing at risk due to a greater workload at a lower rate of pay; 5) are faced with higher rates of stress and burnout; and 6) are forced to sacrifice time that should be spent with family and friends and place the very success of the practice at risk; therefore be it

RESOLVED, That our American Medical Association recognize that there is greater value to the patient, improved access to care, greater patient satisfaction, and improved overall patient care by advocating for a billing mechanism that allows for multiple cognitive services (more than two) to be performed during a single patient encounter (Directive to Take Action).

Fiscal Note: Modest: Between $1,000 and $5,000 to implement

Received: 9/9/2022
RELEVANT AMA POLICY

Evaluation and Management (H-70.961)

Our AMA will work with the CMS to continue to refine evaluation and management coding.

Citation: Res. 804, A-96; Reaffirmed: I-00; Reaffirmed: CMS Rep. 06, A-10; Modified: CMS Rep. 01, A-20

Medicare Guidelines for Evaluation and Management Codes (H-70.952)

Our AMA (1) seeks Federal regulatory changes to reduce the burden of documentation for evaluation and management services; (2) will use all available means, including development of new Federal legislation and/or legal measures, if necessary, to ensure appropriate safeguards for physicians, so that insufficient documentation or inadvertent errors in the patient record, that does not meet evaluation and management coding guidelines in and of itself, does not constitute fraud or abuse; (3) urges CMS to adequately fund Medicare Carrier distribution of any documentation guidelines and provide funding to Carriers to sponsor educational efforts for physicians; (4) will work to ensure that the additional expense and time involved in complying with documentation requirements be appropriately reflected in the Resource Based Relative Value Scale (RBRVS); (5) continues to advise and educate physicians about the guidelines, any revisions, and their implementation by CMS; and (6) AMA policy is that in medical documentation the inclusion of any items unrelated to the care provided (e.g., irrelevant negatives) not be required.

Citation: Sub. Res. 801, I-97; Reaffirmed: I-00; Reaffirmed: CMS Rep. 06, A-10; Modified: CMS Rep. 01, A-20

Preservation of Five Levels of Evaluation and Management Services (D-70.979)

Our AMA will communicate to the Centers for Medicare and Medicaid Services and to private payers that the current levels of Evaluation and Management services should be maintained and not compressed, with appropriate payment for each level.

Citation: Sub. Res. 801, I-01; Reaffirmed: A-06; Reaffirmed in lieu of: Res. 823, I-06; Modified: CMS Rep. 01, A-16

Update on Revision of CPT E&M Codes and Development of Clinical Examples (H-70.921)

Our AMA policy is that future efforts to substantially revise Evaluation and Management (E&M) codes should only occur under the auspices of the CPT Editorial Panel and then through a broadly inclusive process that provides for significant and meaningful input from state medical associations, medical specialty societies and public and private payers.

Citation: BOT Rep. 26, I-04; Reaffirmed: CMS Rep. 1, A-14; Reaffirmed: Res. 816, I-19
Appropriate Physician Reimbursement by Centers for Medicare & Medicaid Services (H-385.952)

Our AMA: (1) opposes both CMS's and local carriers' efforts to reduce or deny physician payments for appropriate services; and (2) will work to assure that all evaluation and management services are appropriately reimbursed.

Citation: Res. 118, I-95; Reaffirmed: A-00; Reaffirmed: A-02; Reaffirmed: A-06; Reaffirmed: A-09; Reaffirmed: CMS Rep. 01, A-19