Moving to More Evidence-Based Primary Care Encounters

A Farewell to the Review of Systems

In the practice of medicine, what is documented in a patient’s medical record helps ensure continuity of care, facilitate coordination between clinicians, support quality improvement and research, can be useful in medical-legal disputes, and, increasingly, makes medical care more transparent to patients. However, over the years, documentation has been increasingly driven by billing and coding requirements. One example is the review of systems (ROS). For decades, clinicians were reimbursed at a higher level by the Centers for Medicare & Medicaid Services (CMS) if visits included an ROS. For example, billing for a “comprehensive” visit was allowed if, among other required components, a “complete ROS” with inquiries about symptoms from at least 10 of 14 organ systems was documented. These financial incentives linked tradition-based care with reimbursement-based care, which could be considered to be care documented largely for billing requirements.

Although it was meant to improve care, performing and documenting completion of the ROS lacked evidence for benefit and inadvertently risked some harm.¹ The ROS can be time-consuming for both patients and clinicians to perform and document. Patients often had to complete a long questionnaire before their visits to satisfy documentation requirements. By eliciting issues that do not concern the patient and determining the clinical importance of these uncovered, often minor, issues, time is lost to address the patient’s primary concerns and important health problems.

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Even more concerning, this type of screening can unintentionally lead to an expensive or even risky workup of nonproblematic symptoms. For example, virtually all patients may have an innocuous change in bowel habit, a common ROS question, from time to time. Even though every clinician most likely could remember an instance in which an important, even lifesaving, problem was identified in an ROS, it is also important to consider the denominator, with numerous ROS involving wasted time that did not reveal important health problems. Additionally, to save documentation time and maximize billing revenue, some electronic health records created visit templates that prepopulated screening ROS questions with patients’ prior responses, introducing the risk of inaccuracy.

On January 1, 2021, previous detailed documentation requirements, including for the ROS, were replaced by CMS with visits reimbursed based on complexity of medical decision-making or total clinician time spent.² Other newer payment models, such as capitation, have also been adopted in some health systems, with insurers paying a set amount for each patient annually regardless of number or complexity of visits. Eliminating the tradition-based ROS can be slow. Electronic medical records still contain ROS templates, preserving ineffective practices. In our practice settings, 18 months after the regulation change, patients are still given ROS questionnaires. Thus, a critical question is how to “de-adopt” the ROS and what should replace it to improve care using the saved time?

This Viewpoint presents ideas on how to use free time during patient visits to achieve better health outcomes based on recommendations from the US Preventive Services Task Force (USPSTF) on evidence-based preventive care including screening, counseling, and preventive medications.

Moving From Tradition- and Reimbursement-Based to Evidence-Based Care

Face-to-face time between primary care clinicians and patients is precious and deserves to be spent effectively to improve patients’ health, including building relationships that facilitate care and improve outcomes going forward. Using the USPSTF recommendations as a guide, clinicians should offer and document services that represent evidence-based rather than tradition- and reimbursement-based care to have the greatest influence on improving health. First, the USPSTF considers both benefits and harms and recommends services that have evidence of net benefit, especially net benefit that is of moderate or greater (A and B recommendations). Second, clinical time should be spent offering care to the right patients at the right time to avoid excessive testing, overdiagnosis, and overtreatment. The USPSTF examines evidence to craft recommendations based on risk factors (eg, age, gender, race and ethnicity, personal or family history) to deliver the greatest benefit. USPSTF recommendations can trigger offers of care (eg, start colon cancer screening at 45 y in the general population) but also identify stopping points when benefits decrease (eg, stop cervical cancer screening at 65 y in average-risk women with...
adequate prior screening). Other USPSTF recommendations target higher-risk individuals for greater health benefit, such as genetic counseling for consideration of BRCA1/2 (breast cancer gene) testing if a patient has a strong family history of breast cancer or other BRCA1/2-related cancers, but against routine genetic counseling for the general population at low risk. Third, time should not be spent offering care for which there is no net benefit or greater harm exists (D recommendations).

Making Time for Shared Decision-making

Many clinical practice guidelines recommend shared decision-making between patients and clinicians to reach the best decision when there is more than 1 reasonable option. With shared decision-making, patients and clinicians discuss different options, including their benefits and harms, and consider patients’ values and preferences in reaching a decision together. The USPSTF has emphasized the importance of shared decision-making for preventive care, which has been shown to improve the quality of medical decisions and increase patient engagement. However, clinicians commonly cite lack of time as a barrier, making shared decision-making another good candidate for use of freed time from not receiving a grant through Massachusetts General Hospital from Healthwise, a nonprofit, outside the hospital from Healthwise, a nonprofit, outside the

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Behavioral counseling is at the heart of several USPSTF recommendations, especially those that involve lifestyle changes. These recommendations include counseling on healthy diet and physical activity to prevent cardiovascular disease (CVD), on overweight or obesity, on smoking cessation, and on prevention of sexually transmitted infections. Rather than obtaining information from an ROS, more time might well be spent on counselling activities when evidence indicates that lifestyle change counseling can meaningfully reduce adverse health outcomes, such as CVD (myocardial infarction, stroke, and peripheral vascular disease), especially for the many US adults with CVD risk factors.

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What Other Tradition- and Reimbursement-Based Practices Might Be De-Adopted?

The ROS is a prominent example of how tradition- and reimbursement-based care may not be evidence-based. Other tradition- and reimbursement-based work, such as certain elements of routine physical examinations addressing asymptomatic body parts and organ systems, may also be candidates for de-adoption. Previously, documentation of physical examinations specified 4 types of examinations (problem-focused, expanded problem-focused, detailed, and comprehensive) that addressed 7 body areas and 12 organ systems. How many minutes of gratuitous lung auscultation could be saved when patients offer no pulmonary symptoms? This time could diverted to addressing services with better evidence of effectiveness or problems and chronic conditions that patients really care about.

Conclusion

New regulations simplifying documentation of services for billing should allow for reconsideration of how time is spent in primary care visits and what really needs to be documented. An initial approach should consider de-adopting the ROS and then carefully considering what other tradition- and reimbursement-driven care could be de-adopted in favor of more evidence-based care. Time saved could be spent on the delivery of proven preventive services including behavioral counseling, as well as shared decision-making to ensure patient preferences as well as best evidence are incorporated into decisions. Thereby, the change in regulations could result in more evidence-based primary care and better health outcomes.

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REFERENCES